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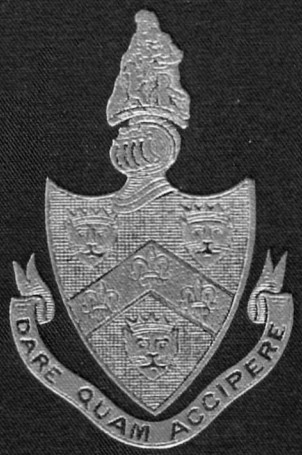

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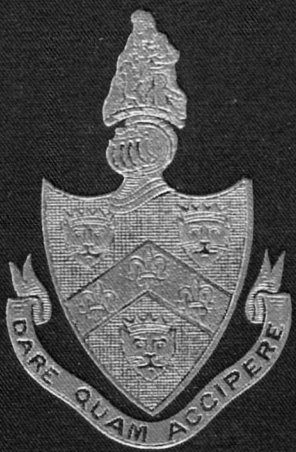

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GUY'S HOSPITAL GAZETTE.

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Passim.

FOR the second time within the short space of one month it is our melancholy duty to record the loss of one of our Consulting Staff. The death of Sir Frederick Taylor, after a long illness, which was reported in the GAZETTE of December 11th, 1920, has been followed by the sudden and unexpected death, which occurred on Tuesday, December 28th, of Mr. Charles Higgens, Consulting Ophthalmic Surgeon to the Hospital since 1906. Only quite recently we had the pleasure of publishing in these pages an article from his pen telling of the part he played in the war (at the age of 70) with much characteristic and downright criticism of official methods. Ever since his retirement from the Staff in 1906 he has been a familiar figure at the Hospital, and he made his last visit to us only a few weeks before his death. Appreciations of Mr. Higgens by Mr. Golding-Bird and Mr. Ormond will be found on page 5. Our readers will join with us in offering to Mrs. Higgens and her daughter our very sincere sympathy.

WE suppose that the patients enjoy the Christmas week in Hospital as much as anybody else, but even they must heave a sigh of regretful relief when the last holly berry disappears from the ward with the dawn of the new year—a year, we hope, of health and happiness for them and of continued prosperity for the Hospital. The ceremony with which the New Year is usually ushered in at Guy's was unfortunately greatly modified this year by the absence of the bonfire. The disappointment at its decease was very great, but it was probably felt more by the enthusiasts of the Borough, who early gathered at their accustomed rendezvous, than by the members of the Hospital themselves. The vast crowd that thronged the front gates witnessed a strange and unlooked-for spectacle. For, at the stroke of twelve, the Superintendent and the Matron issued from their respective doors to exchange suitable greetings on a spot which the assembled multitude had hoped would be unfit for courtesies of such a nature. But so it was, and for the first time for many a year Thomas Guy was left alone to listen to the chiming of the bells, the merry hootings from the steamers and the distant roar of cheering that floats across the river from St. Paul's.

We can only hope that it will not be so in future years. Certainly something is needed to make the celebrations go. It would be a dreary business singing in the dark on a frosty winter night. But we gather that in the days

before a bonfire had become the custom, sufficient cheerfulness and illumination for the traditional singing of "Auld Lang Syne" round the Founder's Statue was provided by torches. We hope that whoever is President of the Residents will bear it in mind next year.

THE medical correspondent of the *Times* is exceedingly upset by the decision of the Ministry of Health to institute medical history sheets for all insured patients, and he quotes the opinion of certain medical men with large panel practices in support of his complaints. It is not that there is any objection to keeping medical histories in theory, but in practice two difficulties are foreseen. In the first place, he argues that the busy panel doctor has no time for the keeping of accurate records, and that, in consequence, the histories will not be properly filled in, or, if they are, that they will be faked. We cannot imagine that it can be the intention of the Ministry to insist that minute details of all the troubles for which patients consult their doctors should be entered on these forms. The nightmare of a panel doctor (so skilfully depicted by Mr. Stanley Cock in our cartoon) sitting up in the small hours of the morning entering up particulars of the 50 odd cut fingers, corns, colds, and so on, that he has attended during the day is merely the fantastic creation of the fevered imagination which regards State Insurance solely as a troublesome interference with the liberty of the doctor. Obviously what is intended is that each patient should have available an accurate pathological record of such complaints as may have some bearing on future treatment or as may be of statistical value. Anyone who has attempted to extract a history from one of the class of patient that finds its way into the wards of the hospitals must realise what an incalculable benefit such a history would be. We believe that the doctors would, in the long run, find that such a system would save them much of the time and labour now spent in investigating difficult and obscure cases. Most panel doctors at the present time, knowing the futility of trying to get clear and accurate histories, make no attempt at such investigations, but send their patients straight to the nearest hospital, often with a tentative diagnosis that makes the House Officer wonder what general practice is coming to. If the medical history cards are used in the spirit in which it is intended that they should be used, the panel doctor will find that he is not only saved much time and trouble, but that his work will become increasingly interesting. Under present conditions his consulting room is inclined to degenerate into a sort of first-aid post from which all interesting cases are at once despatched to the nearest Field Ambulance, namely, the hospital out-patient department.

But there is another and more serious grievance against the Ministry's proposals which the medical correspondent has been ventilating in his columns. It is the intention of the Ministry of Health that the records should be kept by the doctor and that, when the patient is transferred to another doctor, the record should be transferred through the offices of the Insurance Committee. This is regarded as a direct and deliberate blow at the "secrecy" of the profession by which so much store is laid. Let it be quite clearly understood that we realise the importance of secrecy in so far as it results in the complete confidence of the patient in his doctor. The question which the proposed method of disposal of these medical records raises is, Will the confidence of the patient in his medical attendant be destroyed by the knowledge that his medical history is to be handled by the clerks at the Insurance Committee's offices? And if so, Cannot some other method be devised? Certainly the best way

to destroy the public confidence is by a press agitation such as that to which the *Times* medical correspondent has lent the aid of his ever-ready pen. Personally we do not think there is much in it. Patients do not seem to lose confidence in doctors who keep lay secretaries. The records will not be sent to headquarters to be read by a staff of irresponsible flappers or clerks. Even if they were, the chances of one of the clerks becoming acquainted with the secrets of anyone he or she knew anything about would be exceedingly remote. However, it is clear that if the medical records are to be of any value for statistical purposes and for the advancement of the health of the nation, apart from their value to the doctor and the individual patient, someone has got to see them and sift the evidence they contain. In the *Times* of Monday last Dr. Fothergill suggests, very wisely we think, that the study of these records from the statistical point of view might be carried out by, or at any rate under the supervision of, medical officers, possibly the recently appointed Regional Medical Officers who have been the subject of so much caustic criticism on the part of the *Times* correspondent. We agree with Dr. Fothergill that the public must know that their medical histories are not not to be available to any Tom, Dick or Harry at the Ministry or Insurance Committee. Surely it would be quite simple for the cards to be sealed by the panel doctor and for the seal to remain unbroken except when they are in the hands of the final statistician. This would lay the bogey of secrecy.

On Tuesday last our friend the *Times* correspondent excelled himself. Disregarding entirely the value of medical records to the patient and practitioner, he proceeds to demonstrate how useless they will be for statistical purposes. He pitches on one of the diseases which presents the greatest difficulty to statistical study, and draws erroneous conclusions which he applies to every known disease. Being apparently acquainted with the writings of Mackenzie and Lewis on heart disease, he assumes a complete ignorance on the part of the general practitioner of these works—the "New Medicine," we presume, to which he is so fond of referring. Does he really think that only 10 per cent. of general practitioners attain to his own high standard of intelligence? He tells us that nine out of ten doctors, on hearing a bruit, diagnose valvular disease of the heart. Maybe they do, and very likely they are right. But if he means that nine out of ten doctors do not realise that a bruit *per se* does not necessarily indicate valvular disease, then he is hopelessly wrong. The "New Medicine" is not the prerogative of the medical journalist. There is always a "New Medicine," and sincerely do we hope that there always will be. But to assume that the practitioner pays no heed to advances in knowledge which have been made since the day he qualified, is a gross libel on the profession. No doubt, the records will be imperfect. Few records are anything else. But at any rate let us give them a fair trial. Let us not cut down the tree because it does not promise to bear fruit upon every one of its numerous branches.

THE notice of two more demonstrations to be held at Lambeth Infirmary during the coming term (page 9) will be welcomed by all those who have attended the two that were held before Christmas. It serves also to remind us of the problem, as yet far from settlement, of the place that the Poor Law Infirmaries are to take in the future amongst the hospitals of the Country. The *Lancet* for December 25th contains an interesting report of three addresses delivered at a recent discussion at the Har-

veian Society on this important subject. Of these the most interesting, and at the same time the most practical, seems to us to be that by Mr. E. W. Morris, House Governor to the London Hospital.

It appears to be realised on all hands now that the Infirmary must cease to be a pauper institution—that it must be rescued from the administration of the Boards of Guardians. Until this is done, the difficulty of getting patients to go to them (as any O.P.O. can testify) offers an insuperable barrier to their utility. But what is to be the next stage? Are they to become voluntary hospitals or municipal hospitals, or is the Ministry of Health to administrate them as pure State hospitals?

The views expressed in the addresses mentioned above have called forth an indignant rejoinder from Dr. Muir, Medical Superintendent of the Whipps Cross Poor Law Hospital at Leytonstone. He is indignant at the suggestions made as to the inadequacy of the equipment and treatment at these hospitals. Those of our readers who have been to Lambeth will agree with Dr. Muir that all Infirmaries are not "backwaters of stagnation and neglect." Whatever be their ultimate future, certain fundamental principles must be born in mind. We do not want competition of a commercial character between voluntary and municipal hospitals—if they are to be municipal. Moreover, we require all our available clinical material for purposes both of undergraduate and postgraduate teaching and for research. The most complete sympathy and co-operation is needed if there are to be two classes of hospital. Mr. Morris sees the solution along the lines of the Dawson Report, with the infirmaries as the primary centres and the voluntary hospitals as the secondary centres, both to be financed from public funds.

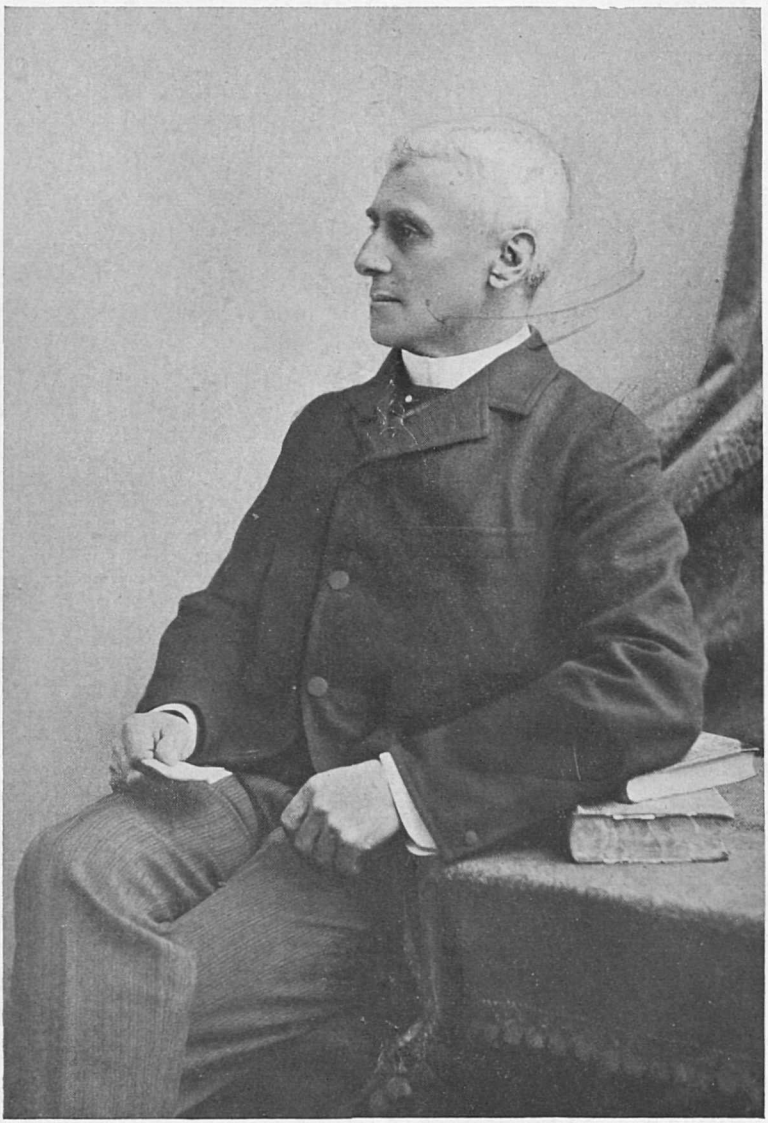
With our own views on hospital finance our readers are already familiar. We are glad to note that at a meeting of the Representatives of the Honorary Staffs of the Voluntary Hospitals the principle that we have advocated in these columns was adopted in a motion by Mr. Bishop Harman, namely, that Government grants to voluntary hospitals should be proportional to the revenue voluntarily raised.

SIR WILLIAM HALE WHITE has raised the question as to whether there is in existence a drawing or photograph of the old Clinical Ward. The series of drawings by Mr. Hanslip Fletcher includes a sketch which takes in a part of Clinical, but there has recently appeared in the College a very excellent photograph which appears to embrace the whole of the south side of Clinical as it appeared before the building operations began. These photographs are for sale, so that we presume that copies are available in large numbers. But it would be a pity not to have the best existing picture of so historic a building perpetuated, and we would ask any old Guy's man who has in his possession a good photograph or other picture including the whole of Clinical to communicate with us so that steps may be taken to have it reproduced.

MAY we remind readers, unless they have already made arrangements for payment through their bankers, that the annual inclusive subscription of 12s. 6d. for the "Gazette and Directory for 1921" is now due, and should be forwarded as soon as possible to the Manager, "Gazette" Office, Guy's Hospital, S.E. 1?

Appointment.

V. A. Luna, Clinical Assistant to the London Lock Hospital, and to the Hospital for Diseases of the Skin, Blackfriars.



CHARLES HIGGENS, F.R.C.S.

Obituary.

CHARLES HIGGENS, F.R.C.S.

TWICE within a month death has demanded a heavy toll of the Consulting Staff of Guy's. In the case of our Senior Consulting Physician the end was not altogether unexpected, and was for him a happy release from a long illness; but that of Charles Higgens must have come to many as a great shock, for so strongly had his personality, in one respect, impressed itself on those who knew him well, that it almost seemed as if the wear and tear of life had no effect upon him, and that he was immune to the common lot of humanity. A wiry athlete, always in the "pink of condition" and holding lightly the threat of advancing years, he was a man of remarkable physique—a boxer, horseman, and all-round sportsman, even late in life; and, indeed, in everything connected with sport, and especially with that relating to Guy's, he took the keenest — and, where possible—practical interest.

When Sir W. Osler, some years ago, stated that a man at 60 was no more useful to the community, Higgens refuted, at any rate, the physical side of the argument, though past that age, by joining in, and winning, a bare-backed donkey race in the Hospital's Athletic Grounds! and where, too, he figured as an active performer for long after; and with equal vigour held his own in his arduous and successful professional duties.

It is such recollections as these that flash to one's mind on hearing that he is now no more: it seems hard to believe the sad news.

A staunch and wise friend, and one who never spoke an unkind word of anyone, he will indeed be missed by all, whilst the profession has lost in him one of its most prominent and valued exponents in ophthalmology. What Guy's owes him for the work done in its wards, Guy's knows very well, and will ever appreciate.

As a teacher, Higgens was unequalled: expressing himself in few words, and often seemingly abruptly, he would at once elucidate the point he desired to make, and impress it with an insistence that compelled both the attention and faith of the student. Unrivalled as an operator, his theatre was crowded on all occasions, and not by students only, for his acknowledged skill attracted many from outside.

Never hesitating and fearing nothing, but never rash, Higgens would tackle anything that came legitimately in his way; and I recollect, many years ago, seeing him ligature the carotid for an angioma of the orbit. On my jocularly remarking that he was poaching on the surgeon's preserves, he remarked, "Well, it had to be done, you see; and I am going to do it. I don't want a surgeon to help me." And right well and quickly he did it, too.

It will be remembered by the readers of the GAZETTE that in his recent communications on his own share of war work, he said that much more might be asked of him than lay within the strict limits of his special department, so he prepared himself by practising general operations with the assistance of the late Mr. Bell. This was characteristic of his thoroughness and of his determination never to be unable to meet an emergency.

His retirement from the Hospital has given time to many men at Guy's not to have known him personally, but the charm of his manner, his marked personality, the soundness of his teaching, and his skill as an operator will never be forgotten by his old pupils, who owe to his thorough and skilful training any success they may have attained in their profesional career; and with them, as with the profession at large, the memory of Charles Higgens will endure for many years to come. C. H. G.-B.

Charles Higgens died suddenly, almost dramatically, whilst out shooting. Active and energetic to the last, his end was probably as he would have wished. His was not a nature adapted to a long, lingering illness, and resignation and submission were not qualities that fitted him. His chief characteristics were cheeriness, equanimity and resourcefulness. You could always ask him what to do in a difficulty, and he would tell you, but it was not always wise to press for an elaborate reason.

His courage, both moral and physical, was unusual, and no one was more ready to do battle with those half honest members of the profession who were willing to trade on the ignorance or credulity of their patients, under the assumption that they would not be found out and challenged. An entirely loveable personality, he enjoyed a popularity unusual and unattained by many, and the number of those who received a helping hand from him in one way or another was considerable.

We laid him to rest on New Year's Day, as the light was fading from the sky in a lovely little village churchyard nestling in the folds of the Hampshire Hills, within sight and sound of that country he knew and loved so well.

A. W. O.

The Prevention of Venereal Disease.

IT is now nearly 16 years since Schaudinn demonstrated the causal organism of Syphilis, and over 40 years since Neisser discovered the Diplococcus of Gonorrhœa. The introduction of Vaccination by Edward Jenner over a century ago has had the happy result of reducing the incidence of small-pox in the British Isles to almost negligible dimensions. The organism which causes small-pox is as yet unknown. But although we know the appearance and behaviour of the organisms of syphilis and gonorrhœa, these two diseases are still the cause of incomparable suffering the world over, and of one, at any rate, the death rate takes a high place in the ranks of mortal illnesses.

The ultimate aim of warfare (so say the military manuals) is the destruction of the enemy's forces. This principle of military science has long been appreciated, but it is only recently that we have realised that quite apart from the human enemy there is another—more deadly, more powerful, more difficult to defeat—the micro-organism of disease. The recognition of this fact was made possible by the work of Pasteur. The wars that took place since his time have merely served to give practical proof to what had previously been theoretical certainty. In our own Boer War the mortality from disease was far higher than the mortality from wounds. The hidden foe destroyed more life than all the arts of man.

The medical history of the recent war has clearly shown that the mortality from sickness can be largely controlled by adequate offensive measures against the causal agents. Typhoid, which laid such a heavy hand on our troops in South Africa, caused few deaths and little sickness, even in the Eastern theatres in the Great War. Vaccination, improved sanitation, and scientific rationing were the weapons used to destroy the forces of the enemy of disease. Nevertheless, there are some diseases which defy offensive action, for we cannot find the means to pierce their defences. Thus, in Gallipoli, while typhoid was a rare disease, thousands of men suffered from the ravages of the entamœba histolytica. Here it was more our inability to use our defensive armament than our ignorance of what to do. If all the drinking water could have been boiled, if every fly could have been destroyed, and if cooking could have been done under conditions of strict asepsis, amœbic dysentery would have been rare indeed. The same inability to use adequate defensive measures allowed trench fever in France to assume menacing proportions. It was known, at any rate in the latter years of the war, that the excreta of lice were responsible for the disease; but how were the lice to be exterminated? It was obviously an impossibility, though much could be and was done by means of "Divisional Baths" and "Delousing Stations."

In a war so prolonged and in which the personnel engaged was so enormous, it soon became clear that the mortality from disease was hardly more important than the incidence of the disease itself. Comparatively few men died. Incredible numbers thronged the hospitals suffering from diseases from which recovery was slow and uncertain. It is no exaggeration to say that the chief of these diseases were syphilis and gonorrhœa.

It is not surprising, therefore, to learn that the means of preventing these diseases which so greatly impaired the efficiency of our forces were very earnestly considered. Ever since the possibility of preventing these diseases had come within the realm of practical preventive medicine, acute controversy has ranged around the methods which should be adopted. This controversy, which had been smouldering in the days before the war, was suddenly fanned into a blaze. The problem was urgent. Upon its right handling victory might depend.

How this controversy started, how it was conducted, and how it ended, is the theme of Sir Archdall Reid's recently published book.* Here he records the efforts made by himself and other eminent medical men in an attempt to eradicate venereal disease from the army—efforts which culminated in the foundation of the Society for the Prevention of Venereal Disease.

Nor many years ago there was a large number of men—not excluding distinguished members of the medical profession—who believed that these diseases were the direct manifestation of Divine wrath for the sexual irregularities of

*"Prevention of Venereal Disease." By Sir G. Archdall Reid, K.B.E., M.B., C.M., F.R.S.E. Messrs. William Heineman (Medical Books) Ltd., London. 1920. Price, 15s. net.

mankind. There appear to be a few who still maintain this attitude, but they cannot be many even in the ranks of the ecclesiastical profession. But there unquestionably is a large and powerful body of men which considers venereal disease a potent deterrent from such forms of immorality. It is this attitude which has been the stumbling block in dealing effectively with the question of prophylaxis.

No one questions the morality of vaccination against typhoid or small-pox (except, perhaps, a few insignificant anti-vivisection enthusiasts). These diseases are not contracted as the result of immoral acts, and can, therefore, have no effect in deterring the prospective sinner. From the point of view of preventive medicine, laying aside entirely all ethical considerations, venereal diseases should be treated in the same way as typhoid and small-pox. In other words, if there is a sure and certain means of prophylaxis it should be universally adopted. Do these sure and certain means exist? This is a question which Sir Archdall Reid answers emphatically in the affirmative.

In March, 1915, Sir Archdall took medical charge of some 2,000 soldiers in Portsmouth. If the results of his experiment are to be trusted —and we see no reason why they should not be—the prevention of venereal disease is a comparatively simple matter. Briefly, what he did was this. He preached the doctrine of personal ablution with some mild disinfectant (*e.g.*, Pot. Permang.) immediately after sexual intercourse. Every man arriving at his station was given a short lecture. The dangers of venereal disease were clearly pointed out and he was instructed in the methods he must adopt to avoid infection. The results were well-nigh perfect. "Immediately," writes Sir Archdall, "venereal disease vanished from my units; for six months not a single case occurred; in two years and four months, during which quite 20,000 men must have passed through my hands, only seven men were infected." Analysing these seven cases, he adds: "Two of these were contracted from their own wives by men on leave. Two occurred in men so hopelessly drunk at the time of infection that they had little or no recollection of what had happened, and could only be sure that they had used no antiseptics. One man joined the station late in the afternoon and contracted disease the same evening. He had received no lecture and had used no disinfectants. The last two men, of whom one developed syphilis, delayed disinfection till they returned to barracks and the ablution rooms, one more than an hour and the other more than two hours after intercourse." Considering the delicacy of the spirochæte and of the diplococcus gonorrhœæ, no one can be surprised at these results. Immediately after the act the organisms are entirely superficial. Probably soap and water would be equally effective, but the use of disinfectant adds to the certainty. We need not labour this point. We consider it clearly proved that adequate ablution properly carried out (and this must be taught) combined, if you like, with the use of calomel or some other mercurial ointment, is as effective a prophylactic as is vaccination against typhoid or small-pox. The question that has to be decided is, "Shall we publish the necessary knowledge broadcast, throughout the length and breadth of the land?"

Sir Archdall Reid and those that think with him have no hesitation in saying yes to this query. But so strong is the opposition that, as yet, practically nothing has been done. Indeed, the steps taken by Sir Archdall Reid at Portsmouth were contrary to his official instructions. The Government policy during the war was inspired by the views of the National Council for Combating Venereal Disease. This body holds views that deserve the serious consideration of the medical profession and of the general public. They are alive to the supreme importance of doing everything possible to eradicate Venereal Disease from the community, but in devising a suitable method they are strongly influenced by purely ethical considerations. We believe that the medical profession cannot afford to lose sight of the moral issue that is here at stake; for if their policy is in direct opposition to the ordinarily accepted moral code they will be in danger of losing much of that respect and confidence which is the foundation of successful medical practice.

The attitude adopted by the War Office to this moral question is summarised in an Army Council letter to the G.O.C. Southern Command, dated March 18th, 1916, which is quoted in full in Sir Archdall Reid's book. In it the following passage occurs: "The Council cannot accept suggestions made with regard to prevention which would imply the adoption of any system of prophylaxis which might be said to afford opportunities for unrestrained vice." Later in the same letter the methods considered suitable by the Army Council are outlined: "In every barrack and camp an organised

system should be established under which soldiers who have exposed themselves to the dangers of venereal infection should be required to attend for treatment within twenty-four hours of infection. Officers should impress upon all non-commissioned officers and men that drugs are efficient to prevent, in the vast majority of cases, the results of self-indulgence, if applied properly and in good time."

It will be seen that the difference between the two contending parties is not very great. The policy of the National Council as illustrated by the above Army Council letter is briefly this: It is wrong to give men the means of prevention before they are infected and to tell them that if they use them they are perfectly safe. That is encouraging vice. Moreover, they add, the method of quick disinfection is not so sure and certain as you affirm, and, by increasing the opportunities for "unrestrained" promiscuous sexual intercourse, you may actually be increasing the incidence of these diseases. Give men lectures, they say. Tell them all about the dangers of venereal disease. Preach continence before marriage. Arrange a system by which men who have been exposed to infection can disinfect themselves within twenty-four hours. And finally provide adequate and early treatment.

The reply of the opposition, now organised as the Society for the Prevention of Venereal Disease, may be summarised thus: We believe, they say, that early disinfection is effective if properly carried out. When it has apparently not been effective the reason will usually be found to be defective methods resulting from imperfect instruction. Twenty-four hours is too long to wait—dangerously long. You want methods that can be adopted anywhere and at any time immediately after exposure to infection. We cannot believe, they affirm, that "unrestrained vice" would follow. There may be a few who remain chaste from fear of venereal disease. Their number is small and not worth considering in comparison with the millions of innocent women and children whose lives might be saved by the procedure we advocate. *You* wish to destroy the innocent with the guilty; *we* risk saving a few of the guilty in order to protect the innocent.

These are questions which everyone must decide for himself. Sir Archdall answers them in favour of the policy of the Society for the Prevention of Venereal Disease. We believe him to be right. His early chapters on the psychological effect of our present system (or rather lack of system) of training children in morality and questions of sex are full of interest, and might well be studied by all parents. It is the author's belief that sexual immorality is more prevalent amongst Christians—especially English Christians—than amongst the members of any other religion of the world. This he traces to our conventional attitude towards sexual matters. Children are carefully preserved from hearing anything of sex even from the purely biological point of view. They are only taught not to steal, not to tell lies, and so forth, and these principles, early instilled, are never laid aside. Sexual morality has to be discovered on their own initiative. By the time that they are given any serious teaching (or more usually preaching) their receptivity is diminished by advancing years. They are no longer impressionable to moral instruction. Hence the widespread sexual immorality of our nation.

From considerations such as these, Sir Archdall believes that the moral teaching of the adult is foredoomed to failure. The control of venereal disease lies with scientific prophylactic measures. To teach such measures to all and sundry is the aim of the Society for the Prevention of Venereal Disease.

We believe that Sir Archdall Reid is right both in his scientific and in his moral thesis. We believe that the simple measures that he advocates are really effective and can easily be taught; and further that morality does not forbid their adoption. We do not feel at all convinced that "unrestrained vice" would follow. Every man knows the sort of reasons that make a man continent or the reverse. Surely the man who is deterred from promiscuous intercourse from fear of venereal disease is rare. But supposing that it were not so. Imagine a race whose morality depended upon fear of consequences. Would a race such as that achieve what England has achieved of recent years? It is unthinkable. We may have a poor opinion of our fellow men, but even the greatest pessimist amongst us cannot imagine so grave a state of things as that. And even if it were true, we doubt whether it would greatly alter our views. The ethics of Christianity are much the same in principle as the ethics of other codes. At any rate all religions which give hope of a future life can hardly regard it as a reasonable proceeding for mortal

man to ensure the lifelong suffering of a few sinners when this involves an infinitely greater number of the innocent—many as yet unborn. The Christian may argue that the innocent who suffer will have their reward. But, on the same line of argument, so will the guilty who do not suffer. It must be our duty to secure the health and efficiency of our people to the best of our ability and to leave all questions of suitable reward for right and wrong to the hereafter.

We hope that it will not be thought that we deprecate moral training. By all means instruct and teach, but do so on rational lines. Instil the principles of morality into the impressionable young when the "bias" of which Sir Archdall speaks can be produced. The doctor has little concern with the moral training of other people's children, but with the attitude of the adult towards sexual questions he may have more influence than anyone else. There is a popular superstition—one responsible for much venereal disease—that continence is bad for the health. We do not believe there are many medical men who hold this opinion, and we are convinced that in teaching prophylaxis the doctor's first business is to emphasise the importance of continence. But, while taking this line, he should be at pains to point out that early disinfection is the only alternative line of safety.

We hope that Sir Archdall Reid's book will be widely read both by the medical and lay public. It is a book for the adult rather than the adolescent. It is, perhaps, a pity that there is no book that we know of which presents questions of sexual morality and venereal disease in a form suitable for adolescent boys and girls. May we express the hope that Sir Archdall Reid, who has proved himself so stout a champion in the cause of the Society for the Prevention of Venereal Disease, will use his literary gifts and wide experience in the production of such a work?

THE EDITOR will, at all times, be glad to consider articles or sketches, provided that they are accompanied by the writer's name and address, not necessarily for publication. The payment that the GAZETTE *can offer is merely nominal. Authors who desire reprints of their papers should make their own arrangements with the printers when they return their proofs. All contributions to be addressed to the Editor, "Guy's Hospital Gazette," Guy's Hospital, London, S.E.*

Interesting Cases in the Medical Wards

Cases under Dr. Hurst, Dr. Hunt, and Dr. Symonds—

Addison	5	Anæmia ? neoplasm.
„	6	Ascending myelitis.
„	11	? Congenital heart.
„	21	Addison's disease.
Mary	21	Aortic disease.
„	23	Exophthalmic goitre.
„	32	Hysterical paralysis.
„	35	Cerebral tumour.

Cases under Dr. Fawcett and Dr. Ryle—

Esther	37	Cerebral tumour.
Stephen	27	? Cerebral tumour, ? G.P.I.
„	28	Henoch's purpura.
„	29	Meningitis.
„	40	For diagnosis.
„	45	Actinomycosis.

Change of Address.

W. Arthur Young, B.Sc., M.B., to 33, Weymouth Street, W. (Mayfair 1858), and "Goring," Stanmore, Middlesex (Stanmore 23).

F. W. Rowland, to Kesterton, Newick, Sussex.

H. Colwell Rook, to Henley Lodge, Taunton, Somerset.

W. E. Tanner, M.S., F.R.C.S., 7, Cavendish Place, Cavendish Square, W.1. Telephone, Western 1847.

Arthur T. Herbert, 3, Valley Drive, Harrogate.

R. J. Hearn, M.A., M.D., B.Ch.Cantab., 55, Wimpole Street, W. 1.

Papers by Guy's Men.

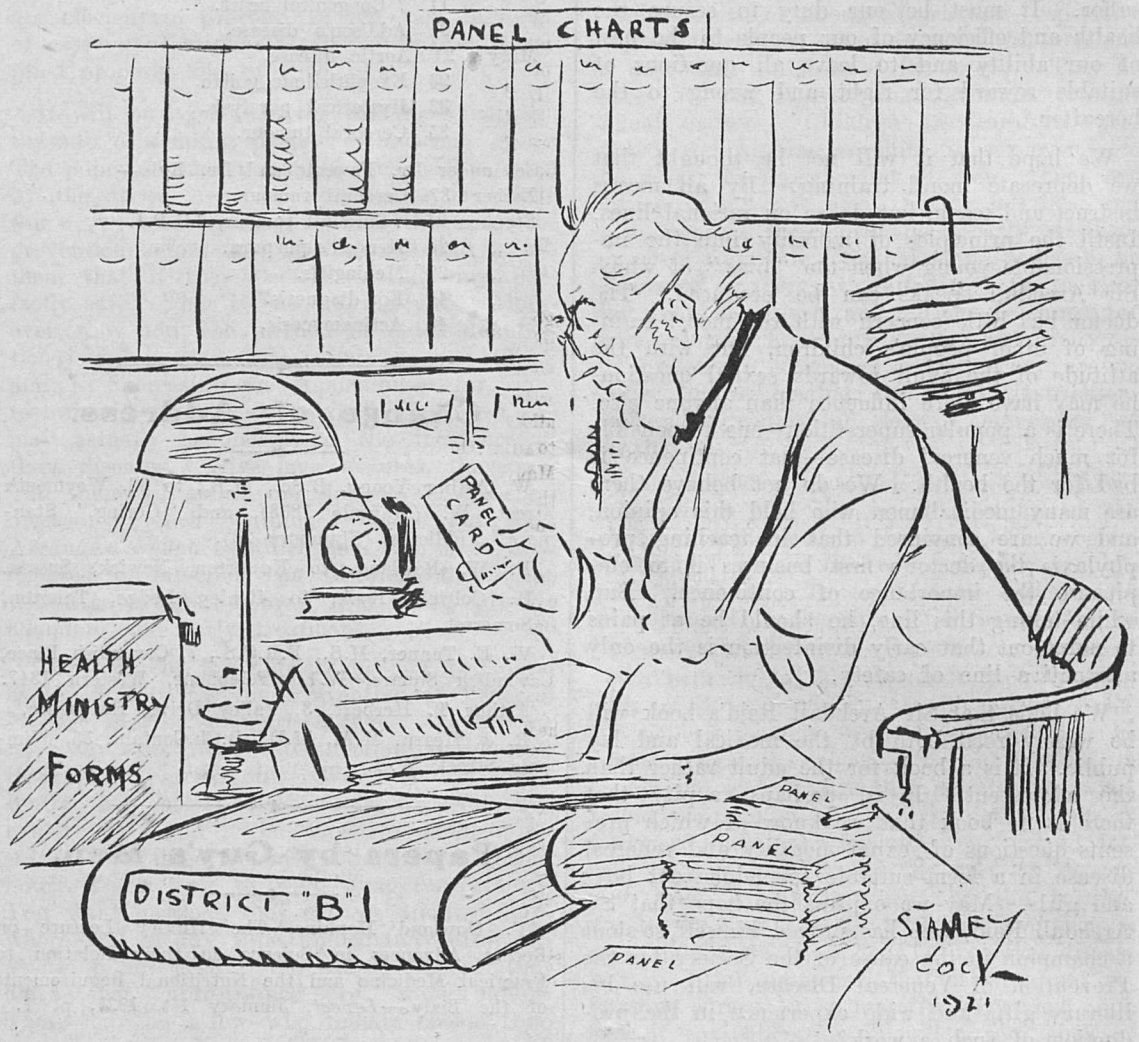
F. Gowland Hopkins, The Huxley Lecture on Recent Advances in Science in their Relation to Practical Medicine and the Nutritional Requirements of the Body.—*Lancet*, January 1st, 1921, p. 1.

Notice.

Guy's Hospital Medical School.

DEMONSTRATIONS AT LAMBETH INFIRMARY.

Two clinical demonstrations on selected cases, for senior students, will be given at Lambeth Infirmary during the Spring Term, on Tuesday, February 1st, at 5 p.m., and on Tuesday, April 5th, at 5 p.m.



"When the Day is over."

THE PANEL DOCTOR: A NIGHTMARE OF 1921.

O. Campion E. J. Crisp W. D. Doherty J. N. Alexander J. B. Gregor E. A. Leviseur K. Woodruff.
C. M. Short E. F. Wilson M. Maizels W. R. Carling W. M. Brown S. Rose G. Siggs M. H. MacKeith A. McKenzie H. A. Harris L. Burville-Holmes L. K. Watson

(Sitting)—D. J. P. O'Meara M. Coburn J. V. C. Braithwaite W. W. Payne C. Gill Carey E. W. Glover W. A. Hawes C. de W. Gibb T. G. D. Bonar V. R. Hirsch S. Massie

THE NIGGERS CHRISTMAS 1920

In the Wake of the Niggers on Christmas Day.

ONCE again, on Christmas Day, the Hospital rang with the thunder of the drum, and the rollicking, but unintelligible, marching song of the Niggers. Why is it, I wonder, that this marching song which is sung far more often than any of the other choruses, is yet, at the end of the day, always the least known of the Niggers songs? I suppose that it must be that the words are drowned by the inevitable jolly peals of laughter which the Niggers'

entrances provoke, together, of course, with the vigorous banging of the big drum, which in a small ward is enough to defeat all attempts to follow the song. However, the tune still rings merrily in one's head, and it matters little what it was all about.

The Niggers this year were fewer in number than we have been accustomed to. They consisted merely of men holding house appointments and a few other men (qualified and unqualified), who were invited to take part because they could sing (an unusual recommendation, in that any voice however tuneless, if sufficiently lusty, is usually good enough for the Niggers). What the Niggers lacked, however, in numbers they made up for in vigour, and even at the end of their tiring day, the choruses were still being roared out with as great a force, if not a greater, than that with which they began.

The costumes, as you may see from the photograph, which the editor has promised to publish, were quite as successful and as variegated as they have been in former years. One of the simplest, yet one of the most effective, costumes, was Mr. Campion's. His burlesque of our hospital barber's rotundity was recognised and cheered everywhere. The barber's walk and mannerisms were well imitated and well sustained throughout the day, so much so, that when the barber recommenced his barbing after Christmas, he was met with many a smile and many a harmless jest from his clients.

The Niggers had many good songs and many good singers this year, but the tradition which demands that a Resident must sing in his own wards, will he, nill he, brought us a few "singers," who would have been far happier had they been allowed to recite their verses rather than attempting to sing them. But after all the chorus is *the* thing. Many clever topical verses had been written for the occasion, several of which were so good that one regrets that they live such a transient life; they seem to us at least, so much better than the original verses. Then of course there were the gags—even more topical than the songs. The puns, the conundrums and the jokes with which Massa Johnson was bombarded throughout the day, came in a never ending procession, each producing ironical applause from the Niggers themselves and many a hearty laugh from their audience.

And so, cheerily, we progressed through wards almost unrecognisable in their Christmas finery till at last we came to the Out-Patients, where our programme told us that the Niggers would lead the children at the Out-Patients' tea in popular choruses. But this was not to be; far from the Niggers leading the children, it was the kiddies (seven hundred strong) that always got off the mark first. As soon as a song was mentioned, and long before the piano had begun the tune, the children had started. The youngsters led always; the Niggers and the accompanist had hard work to keep up with them. Things went with such a will, that there was difficulty in stopping the rapid succession of songs. But at last we are on the move again, off to continue the round in the surgical wards, till at last we reach Astley Cooper: the last songs are sung, and amid vociferous cheers the Niggers return to the College to doff their war paint, thankful that the morrow is a Sunday and an off day in this week of gaiety, so that they may rest from their tiring day before beginning on the almost daily singing which the round of ward concerts demands of them.

ADDISON.

For this concert a fearsome warning was given in a poster depicting "Savage Music" but the concert belied the warning and it was evident that the cheery crowd that assembled were not daunted by the poster's threat.

The first part of the concert was intended for the children, and for it a conjuror had appeared. With the aid of two bright and doubting children he borrowed the usual jewellery from the audience, did many mysteries, gave a series of impersonations (that of himself being excellent), and concluded with a delightful bit of ventriloquy.

Followed—an excellent tea which led gently on to the remainder of the concert; ushered in by a song from Mr. Lloyd and a buxom wench named Pargeter. They put the audience into a high good humour, which was still further heightened by Messrs. Moore, Beccles, Shepherd and Hart, who with their Jazz music, set everyone lilting, and made even the patients feel more mobile.

Topical songs are always appreciated by those "in the know," and judging by the reception of one of these songs, as sung by Messrs. Richards and Wallace, everyone appeared to be very knowing.

Dr. Poulton was welcomed with terrific applause and his song, the words of which were written by Henry VIII., was so well received that he submitted and gave an encore.

Mr. Richards then sang a song beginning "Well set up and handsome," and followed it with an announcement that Mr. Wallace would sing three comic songs. This was a disheartening thing to say about any singer, but when Mr. Wallace had added a few topical verses to his first song and treated us to a few impersonations of personages, we began to hope the warning was true. We were disappointed.

Mr. Burville-Holmes now told us he must go down to the sea again, and immediately after his song we were thrown one of the tit-bits of the evening, namely a dance by Mr. Richards.

The concert concluded with a few selections by the most stimulating Jazz band.

It will be noted that the whole of the second part of the programme was due to local talent, and this makes one think what a wonderful show the Hospital could put up by a combined effort if the trouble were taken to collect these gems.

ASTLEY COOPER.

Astley concert is traditionally the last concert of Christmas week. It is always held on New Year's Eve, and always sounds the highest, the loudest and the longest note in the crescendo of jollity, which the week provides. This year our fun finished far earlier than in other years; there could be no bonfire to round off the celebrations. The concert was enjoyed by everyone though perhaps our enjoyment would have been greater had the boisterous gaiety of a few men at the back, who had dined "not wisely"—been less pronounced.

The concert was exceptional in that it consisted of purely Hospital talent. There were far too many good turns for one to enumerate all those worthy of our appreciation, so that one must perforce praise but a few of those of outstanding merit. Nurse Johnson's violin solos and Nurse Young's songs were very much appreciated by all. Of the Residents, most of whom sang during the evening, Mr. Woodruff justly received most applause. Messrs. Glover and Lansdown sang some very good topical duets; Mr. Hirsch explained, at great length, why he was known (to the nursing staff) as "Naughty Nick"; and Mr. Carling told us of the winter habitat of the common fly. Then there was the "obstetrical" quartette (Messrs. Campion, Hawes, Braithwaite and Hirsch) whose comic entry was very successful. Mr. Hawes was so well made up as a sister that when one first saw him one asked oneself which sister this was, and it was only by his unladylike voice that the illusion was dispelled. Mr. Short, Mr. Massie, Messrs. Pargeter and Lloyd all sang, and all sang well, but one could go through the whole programme distributing well earned praise to all in this way, but this, though just, would be wearisome. We thank Sister Astley for a pleasant farewell evening to the old year, and congratulate Messrs. Gill-Carey and Massie on the success of this concert which they so ably organised.

CORNELIUS.

The Cornelius concert, held on December 30th, was undoubtedly one of the most successful concerts of a very successful series. Despite many counter attractions, it was well attended, and few of the audience regretted their decision to attend this concert.

We began with a few items from local Hospital artistes (Mr. Gallagher sang and Nurse Jackman recited). After this we were entertained by a number of professional artistes who had kindly come to help us with our concert. Miss Olive Sturgess's songs were much appreciated and applauded, and Mr. Lewis Sydney (of the "Follies") brought the ward down with his stories and humourous imitations. Then we were enthralled by two wonderful violin solos rendered by Phyllis Allan. Next, Mr. Feldgate King and Miss Elsie Mayfair sang songs at the piano. Their last song "The Bells of St. Mary's," was very enthusiastically received. Judging from the volume of sound which Mr. Feldgate

King managed to produce from our small piano, one would have thought that he had at his disposal a cathedral organ reinforced with a well timed chime of bells. Certainly he filled the ward with melody as it has never been filled before (not even by a popular Niggers chorus). Miss Ethel Fenton delighted us with two charming songs. Miss Gladys Dawn's songs were, too, greatly appreciated.

We now return to the Hospital talent. Messrs. Woodruff and O'Meara sang to us of Pennsylvania and other delectable places. Messrs. Wallace and Richards sang a topical song which contrived to find the weak spots in the armour of several members of our senior staff. Mr. Watson sang a song with

a distinctly anti-Pussyfoot savour, and Messrs. Lloyd and Pargeter told us what a difference the nurses had made to them.

Finally, Mr. Woodruff convulsed us with a never-ending song sung at express speed and relating the domestic difficulties into which he, as paterfamilias, had fallen when trying to carry out his wife's duties.

Sister Cornelius is to be congratulated for the magnificent way in which she fed the hungry multitude which assembled to listen to this most wonderful concert.

ESTHER.

On the 28th of December, Esther Ward held its Christmas Concert. The entertainment was provided mainly by the "Jazz Beans" Concert Party, who —needless to say—were thoroughly appreciated by both patients and visitors. Throughout the afternoon their lyrics and "patter" aroused unfailing laughter and applause.

In addition the Misses Joyce Coat and Molly ——, contributed not a little to the enjoyment of the afternoon by their clever dancing and singing.

But perhaps the striking originality of the ward decorations was appreciated as much as anything else, by the guests. The Ward was set out to represent an old country village, with its thatched cottages, village pump, church, school and cattle pond, all complete.

The thanks of those present are due to the artistes who provided such an excellent programme for the amusement of visitors and patients, and to Sister Esther and her nursing staff for the general arrangements, and for the excellent tea which was provided.

EVELYN.

A most enjoyable concert was held in Evelyn on Wednesday, December 29th. The concert was given a very good send off by the programme being opened by the Guy's Jazz Band, this band being certainly one of the most successful features of this year's Hospital festivities.

The singing of Miss Olive Sturgess was greatly appreciated, while Mr. Norman Long at the piano kept the audience in peals of laughter. Miss Dorothy Varick, with Cockney impersonations at the piano, gave an entertainment in keeping with her reputation—this being high praise indeed. Altogether the professional talent at this concert was of a standard far above what is usually to be expected.

The inimitable Mr. Woodruff, of course, more than upheld the prestige of the local talent, his performance quite bringing down the house. Those prime favourites, Messrs. Carling and Watson, were also in great form and thus helped to round off a concert whose equal I have never heard in Evelyn before.

The tea provided was of such huge proportions that it says much for the digestive powers of Evelyn patients (not to mention the visitors) that no serious complications were reported during the ensuing days. Our thanks are more than due to Sister and the nurses for the most excellent way in which all arrangements were carried out.

EYES.

On December 28th, lit by the rays of at least two moons, accompanied by their respective owls, the Eye Wards contributed their share of song, dancing and wit, to the glory of the children's festival.

Before a large and distinguished audience, local talent vied with that of several visitors—among the latter being Miss Hoskings and Mr. Hughes who were received with "roars of applause."

Instrumental music by Nurses Johnson, Weirs and Hobbs, provided a pleasant contrast to the vocal items contributed by Nurse Smith, Mr. Short and the Guy's Quartette; the latter fully deserved their reputation as the best company on tour through Guy's this year.

Mr. Watson greatly amused the company by his songs in Native Costume, and Mr. Marais contributed to the success of the afternoon by his masterly 'cello playing. Another feature of the programme was the most graceful and enchanting dancing by Miss Hall.

During the interval a most excellent tea was provided by Sister, to whom, in company with the House Surgeons and Nursing Staff, belongs the credit for the most enjoyable Christmas provided in the ever-popular Eye Wards.

LANDON OUT-PATIENT TEA.

It was 1 o'clock on Christmas Day. Within the lofty edifice, the central hall had been sumptuously, but at the same time tastefully, decorated for the reception of 700 guests.

Crackers of gigantic size were suspended from the ceiling and lighted by electric lights. Flags, holly and evergreens were everywhere. The whole presented the appearance of a children's Banquet. Tables were filled with cakes, buns, oranges and crackers.

Without, a line of vehicles bearing the excited guests stretched from the entrance to Long Lane, and was with great difficulty controlled by the police, whom the children imagined, like themselves, had been invited to the feast.

Some guests arrived on foot. At 1.30 the doors were opened and Sister O.P. with her well known courtesy shook each little child warmly by the hand!!!

At 2 p.m. a Jazz band arrived and the excitement was intense. Some guests were allowed to play the instruments.

At 3 p.m. the "Niggers" appeared on the scene and rendered some very fine classical selections such as "I'm sorry, dear, I made you cry," "Swannee" and "Bubbles."

The audience showed an unusual knowledge of the scores, and it took the united efforts of the police, the O.P. Staff, and the big drum to stop them singing one item in order that the next might be started. The excitement here was at its highest pitch no one being able to induce the guests to keep their seats.

Each guest made every effort to consume at least their *fair* share of the tea, and all casualties were treated in the Front Surgery. So far, none have proved fatal.

Father Christmas then came along and every child went home delighted with a toy and a present.

Any of the subscribers who were present must have been convinced that their money was well spent, as nowhere in the world would it be possible to find so much happiness between four walls as this treat to the Borough children.

The success of the afternoon was the best reward that could be given to those who helped so much, and Mr. Murray Pilcer's Band, which was absolutely "IT."

LAZARUS AND MARTHA.

The Lazarus Concert, held on December 28th. was a credit to all those participating. The now famous Guy's Hospital Jazz Band opened the proceedings with a zest that effectually broke the proverbial ice. Subsequently the enthusiasm of the audience never waned for an instant under the influence of the great diversity of the succeeding items. Two such well known artistes as Miss Erroll and Mr. Rowland Marfitt were among the earlier entertainers, and responded to repeated encores.

Other professional artistes were Miss Gladys Dawn, who sang 'Songs of the Fair" with her usual charming vivacity of expression, and Miss Wolf, whose masterly rendering of several violin solos left nothing to be desired.

Miss Jones' expressive and well modulated voice was greatly appreciated, whilst a touch of local humour was introduced by Mr. Alan McKenzie's sketch "The Guy's Char Lady." Local talent was well represented in Nurse Drabble, whose rendering of "Two Eyes of Grey," received a great ovation.

Miss Elise Hall gave several beautiful exhibitions of ballet dancing.

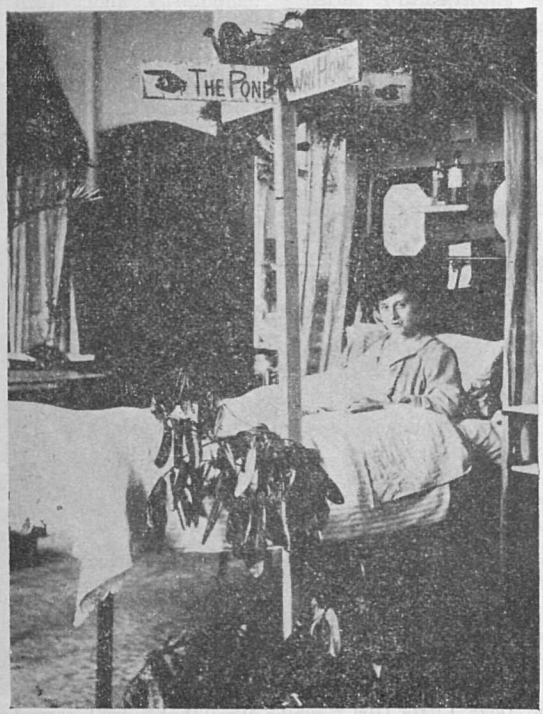
All thanks are due to Mr. Goodyer who competently fulfilled the arduous task of accompanist throughout the concert.

Last, but not least, we congratulate Sister Lazarus and her staff on the excellence and abundance of the tea provided.

The concert closed with the singing of the National Anthem to the accompaniment of the Jazz Band.

LUKE AND CHARITY.

On Christmas Eve the first of the Ward Concerts was held in Luke and Charity Ward. Thanks to the noble response of the artistes an excellent programme was provided. The opening selections were admirably rendered by Mr. Corelli Windeatt and his orchestra. Mr. Thorpe Bates then delighted the audience with his rendering of "Moire my Girl." Miss Nancy Lovatt and Mr. Roy Royston were irresistible in their duets. Once again this year Miss Helen Mar convulsed the ward with her repertoire of amusing stories. The efforts of Mr. Lional King and Mr. Leslie Harris in entertaining were loudly



acclaimed. Mr. Lloyd Chandos was untiring in his efforts to make the assembled company join in his popular ditties.

The concluding number of the first half of the programme was a charming duet by Miss Evelyn Laye and Mr. Thorpe Bates.

After an excellent tea the second half of the programme was entered upon.

Most of the artistes who had contributed to the first half of the programme performed again, aided by Miss Marie Pedley, who was much appreciated.

After a hearty vote of thanks had been passed to all the artistes who had been kind enough to come down to Guy's to perform, Mr. Windeatt's orchestra concluded an excellent concert with suitable selections.

MARY.

The concert in Mary Ward was held on Tuesday, December 28th. Somehow the local talent is always more appreciated at these entertainments than anything else. But if this is so it is by no means any indication of ingratitude on the part of the audience to those, not of the Hospital, who so kindly come and give us of their best on these occasions. In Mary we had a very excellent concert party (from the City, I'm told) who delighted us all with their songs and stories. But the *pièce de resistance* unquestionably was the jazz band, composed entirely of Hospital men, which played appropriate music in the most admirable fashion. Messrs. Lloyd and Pargeter were a very successful pair of comedians and their elocution was more perfect than that of some of the earlier performers. Messrs. Wallace and Richards were offenders in this respect. They had a good topical sketch (I heard it under more favourable conditions elsewhere), but at the back of the ward I could hear little of their words. But these were minor blemishes on an otherwise enjoyable afternoon. It was Sister Mary's last concert and a large party had assembled to bid her farewell. Amongst others in this large gathering we noticed Sir William Hale White, Dr. and Mrs. Shaw, Lady Perry, Dr. and Mrs. Symonds, The Matron and Miss Sheldon.

MIRIAM CONCERT AND CHRISTMAS TREE.

The last Christmas that this dying ward will ever see was probably the happiest in its long life. The patients, although none were fit to be discharged (mirabile dictu), were all convalescent enough to enjoy themselves thoroughly. A short, but excellent, concert was given by Messrs. Short, O'Meara, Watson, Gregor and Braithwaite, after which tea was served and eaten with great enthusiasm. After tea Father Christmas was announced, and entered, amid breathless excitement, by the window, carefully treading on the toes of the House Physician, who had been making somewhat unsuccessful attempts to get his bis-iliac diameter through the opening by podalic version. After the presents on the tree had been distributed, games were played with much fervour by the children—of all ages. Three cheers were then given for Mr. and Mrs. Higgens, who had given the greater part of the presents, followed by another three for Sister. Mr. Leviseur is to be congratulated on his excellent performance of the title rôle.

NAAMAN AND DORCAS.

The Naaman and Dorcas concert was held in the afternoon of December 30th, in Dorcas Ward. We were lucky enough to have some of our best professional visitors to sing for us. None can deny that Miss Hullock's Concert Party was one of the best in the Hospital this Christmas. The audience did not have a dull moment the whole time. When they were not in transports of delight over Miss Gaymer-Lewis' songs, they were convulsed and nearly went into opisthotonus at the sallies of Mr. Barry Linden.

The "local talent" was also greatly appreciated. Nurse Humphreys' voice was as sweet as silver bells, and Messrs. Lloyd and Pargeter strained their voices badly in their efforts to please the big folk in the front pews.

Tea was a scramble and everyone chattered gaily. The end of the concert saw everyone in best of humour.

PATIENCE AND SAMARITAN.

At the Pat. and Sam. concert this year an attempt was made to rival Astley Cooper by depending entirely upon local talent. We were also very lucky in that there was no other concert that day and so more off the nursing staff and students were able to attend.

A most excellent Jazz band started the programme, followed by a topical duet between Mr. Pargeter as a coy flapper and Mr. Lloyd as a clown. Mr. Campion next gave his now famous impersonation of the Hospital barber and was succeeded by a short sketch, well acted by Miss Angus and Mr. McKenzie, in which the visiting staff were gently pilloried.

Mr. Gallagher then saved us from a surfeit of humour by some excellently sung songs. Next appeared the R.O.'s and Mr. Braithwaite. Many were the guesses as to the destination of the new Sister. Mr. Carling and Mr. Short completed an excellent programme. One factor which contributed greatly to the success of this concert was the large number who appeared in costume. Songs, especially of the lighter kind, always seem to have more "go" in them if the artist is "all dressed up." Pat. and Sam. certainly proved the truth of this.

The concert was very successful, and this success must have been very gratifying to Mr. A. McKenzie who is to be congratulated on the excellent way in which he organised this concert.

QUEEN.

Thursday, December 30th, saw this ward in all the glory of its Christmas-tide dress, holding the usual annual concert. Patients occupied the "stalls," and friends packed the remainder of the available space. The chief share in the first half of the programme fell to the artistes whom Mr. Chapple had kindly brought down; well-rendered songs and humorous turns were all appreciated.

After tea, the endogenous talent, who before had played but a sub-ordinate part, almost monopolised the stage; topical songs and similar allusions were appreciated by all, even by the victims of their humour. Hard though it is to distinguish where all the "turns" were so good, mention must be made of one item in particular. The manner in which the "porter" and his confederate treated the unfortunate "patient" temporarily under their charge, and the detached air of the "sister" supervising proceedings, were triumphs of histrionic art.

At the close of the concert Mr. Chapple voiced the thanks of all to those whose performance had made the affair a success; the three cheers awarded, at his call, to the artistes showed how much their activities had been appreciated; yet even they were surpassed by the subsequent applause for Sister Queen.

STEPHEN.

The Annual Stephen Concert took place on the afternoon of the 28th December, before a large and appreciative audience.

The programme was long and varied and was carried through very successfully with Mr. Doherty as M.C. An excellent tea was served during the interval, and for this we have to thank Sister Stephen.

Amongst the vocalists must be mentioned the following:—Miss Remington, whose rendering of Stanhope Martin's "Crown of the Year" was greatly appreciated, it being followed by an encore "I passed by your window." Miss Doherty delighted her hearers by a sympathetic interpretation of "Och! The Dear Little Girl," while Mrs. Walsh well earned her encore of "London Spring Song," by singing "Sink, Red Sun," very effectively. Miss Clark-Smith did not fail to please with "If I could only come to you."

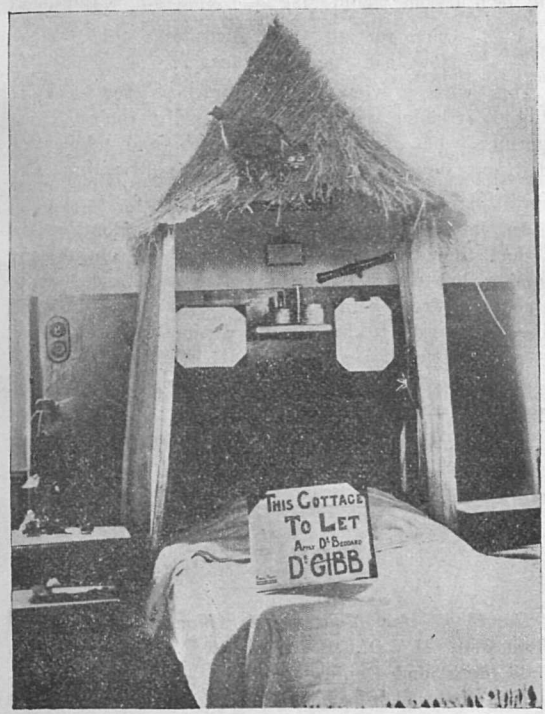
Of the vocalists who still remain to be mentioned "The Split Biffs" contributed much to the amusement of all present, whilst Messrs. Wallace and Richards in "Topical Lyrics," written by the former, showered skit on the Hospital Staff. Messrs. Brathwaite and Burville-Holmes gave their solos with marked success, while Mr. Short, who possesses an excellent tenor voice, was encored after his solo "Joggin' along the highway."

Last, but not least, the instrumentalists gave some charming items. Mrs. Grace played her two items

with feeling, whilst Mr. Marais contributed the well known "Le Cygne," by Saint-Saens, and "Slumber Song," the renderings of which were of a very high standard.

THE LYDIA CHRISTMAS TREE.

The Steward firm had decided to keep up its tradition of providing amusement for the juvenile section of the Hospital. Lydia and Job consequently joined forces, opened the communicating door, much to the delight of the Ward Clerks, and proceeded to prepare for the great day, Tuesday December 28th.



The performance was booked for three p.m., but fully an hour before that, a turbulent stream of youngsters, big ones, little ones, fat ones, thin ones, was making its way into Lydia. From all parts of the Hospital, from the lifts and underground tunnels, up the stairs and down the stairs, they came, some in chairs, others on couches, some carried by nurses, others mounted on the shoulders of ward clerks, and all pushing in the same direction, as if following some Pied Piper of Hamlin.

Lydia Ward itself resembled an illustration from a fairy book. The ceiling and walls had been decorated with ivy and holly, and at the head of the ward stood a huge Christmas Tree, illuminated by many miniature lights and scintillating with innumerable decorations and beads of perspiration from the brows of the industrious ward clerks. On the topmost branch sat a wonderful Fairy Queen, a beautiful piece of work presented by a grateful patient, while in front of the tree were several stacks of toys for the young guests.

At three o'clock, the band, consisting of the Punch and Judy showman, who manipulated a combination drum and whistle, played the overture. Punch then appeared on the scene and in true Christmas spirit, immediately proceeded to knock off Judy's head. The young audience clapped approval, but somewhat resented Punch's attempt to treat the head of a performing puppy in a similar manner. Punch, of course, met a well deserved end by having his own head somewhat roughly treated by the beadle.

Tea, sweetened by many smiles, was then served by the nursing staff, while Sister Job attended to an overflow meeting in her own ward. Very fortunately for the tummies of the young visitors, Father Xmas soon put in an appearance, seated on a decorated chariot (thanks to Evelyn for the stretcher), drawn by a prancing steed, on the back part of which was mounted an assistant Father Xmas, he drove to the tree and proceeded to hand out his presents. His steed unfortunately developed respiratory difficulties and was forced to lie down, by numbers from the rear, while a voice from its mysterious interior called piteously for a couple of towels and a cylinder of oxygen. It, however, recovered sufficiently, after a nurse had rendered first aid with several cups of tea, to stamp its approval, when Father Xmas, by now in a somewhat hoarse condition, called for cheers for Mr. Steward and Sisters Lydia and Job. The departure of Father Xmas with his assistant concluded the performance to the regret of the audience. THE STEED.

Pass List.

University of London.

SECOND EXAMINATION FOR MEDICAL DEGREES. PART II. DECEMBER, 1920.

C. H. Atkinson. †James Jemson.
H. Seelenfreund.
†Distinguished in Physiology.

M.D. DECEMBER, 1920.

Medicine.—E. D. Scott.
Midwifery.—H. W. Evans.

M.S. DECEMBER, 1920.

L. N. M. Reader. C. S. Lane Roberts.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

Malaria.

SIR,—Will you be good enough to grant me space to thank your correspondent, Dr. P. Seymour Price, for his kind appreciation of my article on Malaria, notwithstanding the fact that in some details my views materially differ from those of the Experts of the War Office and Ministry of Health.

The recent fatal case of cerebral malaria recorded in the *British Medical Journal*, should cause practitioners to be on the look out for malaria, though why certain experts should try to suggest that this case was one of direct blood infection, when there are at least two and probably three malaria carrying anophelines distributed over a great part of England, I do not understand.

I quite agree with your correspondent as to the value of intra-muscular caco-dylate injections, though I use rather a different formula from the one he mentions—I also, before the war, had a case of benign tertian which seemed to entirely clear up after prolonged injections.

I would take this opportunity to pay a special tribute of thanks, among the many devoted workers of our profession in the Salonika Army, to Colonel F. Smith, A.M.S., and Dr. A. E. Barnes, Sheffield University, for their kind help at all times, and their untiring energy in dealing with the problem of malaria.—I am, Yours faithfully,

G. W. C. HOLLIST.

Otley,
Ipswich.
December 29th, 1920.

The Niggers at Lambeth.

DEAR SIR,—May I be allowed, through your columns, to thank the members of the Guy's Concert Party for the entertainment which was given at the Infirmary on the 28th instant, which was very much appreciated both by the patients and staff, a considerable number of whom were able to be present.

The amount of energy displayed was truly marvellous when it is remembered that the entertainment was given immediately after, what must have been, a very exhausting week-end at the Hospital.—Yours faithfully,

A. SAMUEL BALEY,
Medical Superintendent.

Lambeth Infirmary,
Brook Street,
Kennington Road, London, S.E. 11.
December 31st, 1920.

The War Memorial.

DEAR MR. EDITOR,—Touching "Subscriber's" letter of November 27th, the prose statement of the great event can be accurately worded without difficulty, which could be put both inside and outside. I am only really concerned about the few words, which might be written on the inside for Guy's men to be often seeing. "Died for their Country, 1914-1918," is to me cruelly bland.

I would wish for some words akin to the mind of Tennyson, who took about 16 years to empty his heart into the "In Memoriam." The pathos and sentiment (and what are words without spirit) of my own bosom would sing:—

Once for all they gave their all
How can we once forget?

This with a view to put into as few and as simple syllables as possible not only their "great sacrifice," but our soul response to, and admiration of, their devotion, and so represent literally "sermons on stones."

An important mechanico-artistic consideration is, I feel, how to make the letters both inside and outside, but especially inside, stand out, and how to save them from being filled up with dirt. I would like the words to be always distinctly visible, even at some little distance. I would wish the arch and wording to be kept ever bright and clean with periodical renovations.—Yours, etc.,

A. WITHERS GREEN.

December 22nd, 1920.

Reviews.

Handbook for Tuberculosis Workers. By Noel Bardswell, M.V.O., M.D., F.R.C.P. (Messrs. John Bale, Sons, and Danielsson, Ltd.) Price 1s. 6d. net.

This little handbook is a good illustration of the fact that the more an author knows of a subject the more likely he is to be able to write about it in a manner suitable for the information of those who know nothing about it. It is not addressed to either doctors or nurses, but to social workers on insurance committees, on after-care committees, or on committees of management of sanatoria, and for such persons it should prove a trustworthy guide. It avoids the mistake so common in books written by doctors for non-medical readers of entering into details which, if they are apprehended at all, are likely to make the less intelligent reader a critic of, rather than a cooperator with, the medical attendant and nurse in charge of the patient. The book is full of common sense and sane advice, and should prove very stimulating to the sympathy of those paid or voluntary helpers who are devoting them-

selves to the uphill task of smoothing the path of patients struggling against the social handicap imposed by a tuberculosis infection.

The sense which pervades the book is indeed so common that one almost wishes it made a wider appeal and was addressed to all those who are trying to smooth the path of the afflicted whatever the cause of his affliction. After reading it one wonders whether there is sufficient difference between the problem of dealing with the patient handicapped by tubercle and the patient handicapped, let us say, by chronic bronchitis or valvular disease of the heart to justify the establishment of a special class of tuberculosis workers. If one reads carefully the admirable sections headed, "The Functions of a Care Committee," "Money," "The adjustment of Financial Troubles," "Remedying Insufficient Income," "Occupation," "Change of Employment," and "Vocational Training," and alters the words "tuberculous person" wherever they occur to "the invalid," and at the same time pictures to oneself a patient convalescent from any sort of illness which is liable to recur one will find that the author's suggestions are entirely applicable.

Now that the false start made in the original Insurance Act of endeavouring to deal with the tuberculosis problem in a watertight compartment is on the eve of being remedied, may we not hope that the machinery of sanatoria committees and after-care committees may be made available for all classes of persons handicapped by ill-health. In a crusade for meeting this handicap Dr. Bardswell's sound humanitarian principles as set forth in this handbook should prove invaluable.

Gout. By L. J. Llewellyn, Senior Physician Royal Mineral Water Hospital, Bath. (Messrs. William Heinemann.) 1920. Price 30s.

Gout is one of the great historical diseases. From the aphorisms of Hippocrates to the writings of the great physicians of the last century, the references are countless. Hardly more than fifty years ago Rush could write of it as follows:—"The great toe is no more its exclusive seat, than the stomach is the throne of yellow fever. . . . The whole body crouches before it. . . . It produced a bubo in the groin of a citizen of Philadelphia. He had never been infected with the venereal disease. . . . Scrofula and dropsy are the effects in many cases of a disposition of the gout to attack the lymphatic system." But with the growth of modern pathology its field has been sadly circumscribed. The joint affections of syphilis, the visceral pains of tabes, gonococcal arthitis and the enormous group of infective arthritis have been established on a firm basis and can no longer be confused with gout.

The author defines gout "as a hereditary disorder the intrinsic element of which is an inborn instability of nuclein metabolism which may remain latent, but under the influence of certain extrinsic factors may become manifest as betokened by local inflammatory reactions mainly in the joints associated with the deposition of urates." In the absence of the latter it can not be diagnosed, and during the last ten years he can not recall a single patient admitted to hospital suffering from the "irregular" gout so well known in medical literature; and later he arrives at the conclusion that it is unwarrantable to speak of gouty ocular disease.

The discovery of Garrod of uric acid in the blood in gouty patients seemed to have established the disease on a firm basis, but since this has been found in many other conditions and modern physiological research on the metabolism of the uric acid group has revealed little or no abnormality in gouty subjects, and perhaps finally we shall be left with the conclusion that gout, once the disease of the respectable and learned is little more than a clinical grouping of patients, the subjects of chronic interstitial nephritis with uratic deposits in their joints, which are at the same time the seat of infective arthritis or degenerative changes.

The author has great experience of the treatment of all these associated conditions, but of the specific action of colchicum he has little to tell us. Its use dates back to antiquity; in the days of Sydenham it had fallen into disuse, but it has again been revived, although the pharmacologists have found little except its action on the leucocytes and on the gastro-intestinal tract.

The book is of great historical interest but of the other aspects, there is only a very small proportion which can strictly be regarded as dealing with the pathology and etiology of gout.

Physiology. By Ffrangcon Roberts, M.A., M.D. Camb., M.R.C.P.Lond. Students' Synopsis Series. (Messrs. J. and A. Churchill, London.) 1920. Price 15s.

A synopsis is an evil, but a very necessary evil. Though it tempts one to neglect that wider reading which is essential for a true knowledge of one's subject, yet it is extremely useful, in that it epitomises the subject into a convenient form for pre-examination revision.

Dr. Ffrangcon Roberts has written a new and very readable synopsis of physiology for the Students' Synopsis Series. Brevity, of course, and the demands of the examining bodies, prevent his introducing much interesting information on some of the more recent clinical applications of physiology (for example, the subject of blood transfusion is not

dealt with). On the other hand, the pure physiology is brought well up to date—the subject of vitamines, for instance, is concisely described and in accordance with the latest work on these accessory food factors. The last chapter (on the defences of the body against infection) provides a welcome link between physiology and elementary pathology.

The book is well written, and though, perhaps, inadequate for men taking the University Examinations, should yet prove of the greatest use to those that are studying for the less stringent tests of the Conjoint Board.

Synopsis of Surgery. By Ivor Back, M.A., M.B., B.C.Cantab., F.R.C.S., and A. Tudor Edwards, M.A., M.C.Cantab., F.R.C.S. (Messrs. J. and A. Churchill, London.) 1921. Price 15s.

This work purports to meet the requirements of the less industrious majority of medical students, and is, from this standpoint, satisfactory. Its aim would be better served, however, were a few pages devoted to the description of surface markings, and the meagre references to differential diagnosis greatly extended.

The insinuation that Sclavo's serum for anthrax should be administered intravenously in severe cases only, suggests that the author's acquaintanceship with this disease is very limited.

We regret to see a further promulgation of the fallacious statement that during the reduction of an intussusception, the intussusception should never be pulled. This method is usually highly successful and its risk is infinitely less than that of resection.

Brevity has been carried to an extreme, notably in the section dealing with cleft palate, in which no mention could be found of the extreme importance of securing an anatomically perfect soft palate; whilst in the same section, Brophy's operation, the only one aiming at a true anatomical restitution of the parts, is summarily dismissed on insufficient grounds.

The statement which occurs on p. 349 that for gall stones cholecystectomy is indicated only if the gall bladder is gangrenous or malignant is scarcely in accordance with modern views.

The chapters dealing with venereal diseases, abdominal surgery and fractures are very excellent, whilst the clear manner in which the subject matter is presented is above all criticism.

Elements of Medicine. By Alfred H. Carter, M.D., M.Sc. Revised by Alexander G. Gibson, M.A., D.M. Oxon., F.R.C.P.Lond. 11th edition. (Messrs. H. K. Lewis & Co., Ltd., London.) 1920. Price 16s.

That this book has found its way into an eleventh edition is a testimony to its popularity with its readers. We cannot imagine that it can have a very wide appeal. It only claims to be an "introduction to medicine," and it is indeed no more. Its chief value must be to the ward clerk who finds himself in the wards for the first time. By enabling such to get a good though brief introduction to the whole subject it should be really useful. But it is important that books of this sort should not be used for a purpose for which they are not intended. An introduction to medicine is worse than useless for an examination candidate. For him the larger text books are the only adequate source of knowledge.

It is somewhat surprising to find what a lot of information has been compressed into this small volume. It appears to be accurate and up to date. We have no hesitation in recommending it to the real beginner if he will promise to discard it when its contents have been thoroughly mastered.

The Theory and Practice of Massage. By Beatrice M. C. Copestake. Third Edition. (Messrs. H. K. Lewis & Co., Ltd., 136, Gower Street.) Price 12s. 6d. net.

This book has now reached its 3rd edition and much has been added since the first publication of 1917. The principal addition to the text is the chapter on Muscle Re-education, the importance of which is clearly brought out by the author. The subject of Muscle Re-education greatly adds to the value of this already useful work, which in the past has proved of great use to the students in training for the Examinations of the Inc. Soc. Tr. Masseuses.

Aids to the Diagnosis and Treatment of Diseases of Children. By John McCaw, M.D., R.U.I., L.R.C.P. Edin. (Messrs. Balliere, Tindall and Cox.) pp. xii.-404. Price 6s. net.

The 5th edition of this volume of the Students' Aids series has undergone careful revision. Considering the size of the book, a great deal of information has been compressed into its pages. It is still unnecessarily dogmatic on certain debatable points, but for those who wish to gain just that amount of knowledge of Pediatrics to enable them to pass a qualifying examination a better book could hardly be found.

Birth.

STEBBING.—On December 21st, 1920, at Brigown, 20, Telford Avenue, S.W.2, Margaret Warburton, the wife of George F. Stebbing, of Lambeth Infirmary, of a daughter.

Death.

EMMS.—On Saturday 25th December, 1920, at "The Cedars," Thurscaston, Leicester, Alfred Wilson Emms, M.D., and J.P. for County Leicester.

ED.—M. E. S.

GUY'S HOSPITAL GAZETTE.

VOL. XXXV., No. 849.] JANUARY 22, 1921. [NINEPENCE.

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Passim.

THE New Year's Honours List appeared too late to enable us to make any reference to it in our last issue. It is always with a feeling of mild excitement that we open our daily paper on the mornings of the New Year and the King's Birthday. It is unusual on such occasions not to find a few names in the Honours Lists which are more than names, and the recent list was no exception, for did it not contain the names of the editors of our two distinguished contemporaries, the *Lancet* and the *British Medical Journal?* There is no precedent for the honour conferred upon these two eminent gentlemen, and we congratulate them on having earned so unique a distinction.

Guy's men must all have felt some disappointment that the list did not include one of their number. Whatever our individual views on the conferment of titles in the abstract may be, we all like to see the Institution to which we belong honoured through the men who do so much to make and preserve its great reputation. It was, therefore, with unmixed feelings of pleasure and satisfaction that we, and all Guy's men, read in the papers of Wednesday, January 12th, that the King had been pleased to confer the honour of Knighthood on Dr. Maurice Craig. So well known is the man and his work that it is unnecessary for us to enlarge upon such a theme, save to offer our hearty congratulations to the recipient of so well-deserved an honour. We think our congratulations should be extended also to the Medical School Office for their commendable promptness in recognising our new knight. The first intimation that we personally had of the event was a notice posted in the Colonnade on that very Wednesday morning to the effect that "Sir Maurice Craig" would lecture at 12 noon that day. If only they could be equally prompt with those Appointment Lists!

TALKING of congratulations reminds us that a correspondent wrote some time ago to draw our attention to a grave error of omission that we had committed. He complained that two Guy's men had been appointed to the Staffs of other Hospitals without reference having been made to the fact in the pages of the GAZETTE. We must admit that this is so, and we apologise to the gentlemen concerned for our inhospitable conduct. To those who have been working at the Hospital for the past six months it is old news that Mr. Mullally is now Assistant Surgeon to the Westminster Hospital and Dr. T. I. Bennett Assistant Physician to the Middlesex. Our congratulations are not the less sin-

cere on account of their lateness. If it is with regret that we lose the services of so many of our brilliant men, it is some satisfaction to know that the other teaching Hospitals are the gainers thereby, and we cannot be sorry that the traditions of Guy's teaching are thus disseminated through the London Medical Schools. Mr. Mullally will not find himself alone as a Guy's man at the Westminster, but we believe that Dr. Bennett is the only Guy's man at present on the Staff of the Middlesex. Once more our congratulations and apologies.

ALREADY the War Memorial is beginning to take shape. Enormous blocks of stone are daily deposited inside the Maze Pond Gates, and are being shifted into their appropriate positions by a system of spars, ropes and pulleys that look as if they had been based upon the drawings of Mr. Heath Robinson rather than the standard text-books of mechanics. At any rate the results seem to justify the means and it looks as if the Memorial would be completed within a month or so. Indeed, the next few months will bring about a great transformation in the appearance of the Hospital. The new building is nearly completed, and the remains of Clinical are, we understand, to be demolished very shortly. Preparations are already being made to remove the pillars that adorn the south end of the Park, and these are to be incorporated in the Memorial Arch. In the place of the Arcade which these pillars at present support is to be erected a temporary Baby ward to enable the demolition of Clinical to be completed almost at once. A further significant development is to be an increase in the number of maternity beds. These are to be put on the top floor of Hunt's House as soon as the new building is sufficiently advanced to allow of the removal of the Electrical and Massage Departments at present housed there.

All this building has necessitated the cutting down of a good many trees, and we publish this week a letter from a "Resident" deploring, more especially, the loss of the tree which has recently disappeared to make way for the War Memorial. The trees in the Park are not an unmixed blessing. In the summer time they shut out a lot of sun and light from many of the wards, and it is, of course, quite impossible to grow satisfactory grass on ground which has to provide for the metabolism of so extensive a forest. Personally, we think that little harm would be done, either from the æsthetic or health point of view, if rather more drastic steps were taken with some of the trees. They are certainly attractive to the eye, but in this case surely the half is greater than the whole. A few judiciously placed trees look just as well as a large number crowded into a space that is much too small to hold them. And there are other disadvantages. We were walking through the Park in the twilight the other day when a well-known voice hailed us from behind. "Mr. Editor," it exclaimed. "Sir," we replied, with the respect due to so exalted a glottis. "Will you," it continued, "voice a grievance for me in your valuable journal?" We consented. "These birds!" was the rejoinder.

WE should like to draw the attention of all our readers to the notice of the Hospital Ball, which will be found on page 36 of the present issue. It is to take place this year at the Hotel Cecil, and Lady Goschen is to be the Hostess. It will be noticed that the tickets (25s. each) are rather more expensive than they have been on previous occasions, but it will be obvious that such things must cost more under present economic conditions. The committee have spared themselves no pains to make the dance a real success, and we hope that their

efforts will be rewarded by the support of all Guy's men. From what we have heard the price of the ticket will be money well expended. The band, we understand, is beyond reproach, and the supper menu, which we have been privileged to see, is a dream of gastronomic art. We only hope it may not prove a nightmare. The date is February 2nd, and all details will be found in the notice on page 36.

WE are pleased to hear that the two dances given in the Court Room during the week before Christmas, by the Committee of the Guy's Hospital Ladies' Association, realised £140 towards the £500 required for the endowment of a Cot.

This Fund was started by the Junior Members of the London Branch last year, and the Ladies' Committee hopes that the remaining £100 required for its completion will be subscribed by the well-wishers of the Hospital during the present financial year, which ends on March 1st.

New Members are urgently needed in order that the work of the Association may be increased. The Committee are making an earnest appeal to the wives and relatives of all Guy's men and also to former Sisters and Nurses to become members and to endeavour to secure the interest of their friends.

All information will be supplied by the Hon. Secretary, Mrs. Philip Turner, 73, Wimpole Street, W. 1.

MAY we make an appeal to our contributors to be careful always to *write on one side of the paper only?* The GAZETTE is a very long-suffering journal, and many manuscripts have been accepted for publication which the editor of any other paper would at once have consigned to the waste-paper basket. Hand-writing is a minor detail. Our own is not above reproach, but the printers are wonderfully skilful in dealing with it. But paper with writing on both sides causes a lot of trouble, and we hope that all our contributors, especially reviewers and those who so kindly supply us with notes of Hospital Athletics, will bear this in mind.

WE are asked to announce that the 22nd Annual Dinner of the Guy's Hospital Dental Society will take place on Saturday, February 12th, at the Hotel Cecil, at 6.30 p.m., with Mr. E. B. Dowsett, the President of the Society in the Chair. During the afternoon the Dental School Buildings will be open and clinical cases will be shown. It is hoped that not only the Dental, but the Medical side of the Hospital will be represented. Tickets, price 15s., are now obtainable from the Hon. Sec., Mr. H. A. Coysh, and from Messrs. R. Hughes and K. Hooper.

ANOTHER forthcoming Hospital function is the Annual Concert of the Musical Society, which is to be held on Shrove Tuesday, February 8th, at 8 p.m. This will be the first concert to be given since the war, and we understand that the Society has secured the services of Mr. Clive Carey as soloist. We hope that a large company will gather to greet Mr. Carey on his return to a stage on which, in earlier days, he was a well-known and ever-popular figure.

WE have great pleasure in announcing that the sale of the Christmas Cards, so generously presented by Messrs. Ash & Co., has realised the splendid sum of £56 9s. 3d., and that this amount has been handed over to the Hospital Authorities.

Some Urgent Urinary Cases.

CLINICAL LECTURE BY MR. THOMPSON.

GENTLEMEN,—The first urgent urinary case that I ask you to think about is perineal abscess. The cause of such an abscess is stricture of the urethra following upon gonorrhœa, or less commonly, trauma. The symptoms are: pyrexia, pain, and the formation of a tender, hard swelling situated symmetrically in, and on either side of, the middle line, usually in the front part of the perineum, and extending forwards into the scrotal region.

Two symptoms are not present, as a rule (*never*, in my experience), which might reasonably be expected. Their absence tends to mislead one. These two absent symptoms are:—(1) retention of urine; (2) fluctuation in the swelling indicative of pus formation. Far from there being retention, there may be no reason from patients' statements to suspect difficulty in micturition. The swelling may be so hard as to be mistaken for an osseous or a sarcomatous condition. This is very important: Every hard median swelling situated in or adjacent to the perineum should be diagnosed as perineal abscess.

PATHOLOGY.

1. Stricture of the urethra.

2. Distension of urethra and urethral glands behind the stricture. The glands are mostly situated upon the floor of the urethra. Hence incidentally always keep the point of an instrument upwards during passage along urethra in any case demanding instrumentation. Hence also the formation of an abscess on the ventral, and not dorsal, aspect of the urethra.

3. Collection of urine in the glands.

4. Decomposition of urine in the glands.

5. Blocking of gland entrance into urethra, and formation of abscess on outer side of gland, and spread of abscess formation into perineum.

6. The abscess may (1) burst into urethra. I have never seen this, and should never think of anticipating or waiting for it. Or (2) burst externally. This would reflect no credit on anybody. Or (3) may produce a rapidly spreading cellulitis or extravasation of urine.

TREATMENT.

1. Administer the usual drugs and anæsthetics. Place the patient in the lithotomy position. Palpate the swelling, and lay the swelling open along its whole length, and incise until you find pus. But do not of design incise the urethra. The pus may not only be deep, but frequently is also loculated. A free incision is therefore necessary.

2. Place sulphur in the wound. Sulphur is an admirable powder to lay on this offensive wound, and by its use you get a clean slough.

The last thing I am going to put down in capitals. LEAVE STRICTURE ALONE. Why should you touch it? The patient has got so little idea of it that he has given you no history of it. He is passing water alright. Leave stricture alone. That is very important to bear in mind.

This is a long story, and implies an ascending nephritis. I do not think anyone will understand ascending nephritis until they read the article on Ascending Nephritis in "Erichsen's Surgery." The last edition was published in 1894 and edited by Marcus Beck and Raymond Johnson. Marcus Beck did a great deal of original work on ascending nephritis, and his work is copied very feebly into modern textbooks on surgery. Ascending nephritis is emphatically an affection of the lower urinary tract, passing up the wall of the ureter and spreading itself to the capsule of the kidney, and is therefore an acute and interstitial nephritis. It may leave the bladder untouched.

Supposing you dilate the stricture, you may infect the urethra; and secondly, you may damage the stricture area. You may open lymphatics which you specially should not open. These lymphatics being distended, any infection spreads like wild-fire into the kidneys without touching the bladder in many cases.

2. ACUTE RETENTION OF URINE.

Causes—

1. Stricture of the urethra following upon gonorrhœa or trauma.

2. Enlarged prostate. But absolute retention is rare with enlarged prostate, except it be malignant. Malignant prostate is not a very common condition, but if it does give rise to acute retention, it gives rise to absolute retention.

3. Nervous disease and injury.

4. Vesical calculus.

5. Acute gonorrhœa.

6. Abdominal catastrophes, *e.g.*, perforated duodenal ulcer.

7. Congenital conditions. Some of you may argue that enlarged prostate goes on to acute retention more commonly than gonorrhœa. Admitted, if acute retention is retention with overflow; but not admitted if retention is defined only as absolute retention. With regard to congenital conditions I have seen two cases, in boys, of much distended bladder relieved by the passage of the catheter, but on which I have no further observation to make.

If you get retention with overflow, I do not think you often get it with stricture. I think you get it very frequently with enlarged prostate. You also get retention of urine and overflow with an impacted calculus in the urethra in the middle line.

Examination and Treatment.

The two go together very much. In all cases of acute retention you should refrain from local examination until you are prepared to treat the condition from which the patient is suffering. Or the diagnosis must rest upon probabilities, at any rate, first. Under forty years of age *you will think, first, of stricture.* Over fifty you will think of enlarged prostate. But do not examine the rectum. By so doing you dilate the anal sphincter, and may upset the musculature of the bladder and urethra. You will then proceed to wash the meatus urinarius, and palpate the penis.

Test for Nervous Disease.

The point here is that the patient is not made any more anxious during all this examination. You are not hurting him. Perhaps you are inspiring confidence in him. That is very important in passing any instrument upon him. An impacted calculus may be felt. A stricture may be palpable, or pus may be extruded from the meatus. Always bear acute gonorrhœa in mind.

When you have washed the meatus urinarius and palpated the penis, what do you do next? The rule is perfectly simple. I have come to the conclusion that the following rule is the best to adopt. Under forty, pass a No. 2 G.H. catheter. Over fifty, pass a No. 10 coudé catheter. The point is, you are not going to frighten the patient with either of these instruments; and a man who is competent to take up a No. 2 G.H. catheter at once and without hesitation is not going to produce a false passage. For those over fifty, a No. 10 coudé catheter is not sufficiently large to be frightening, and it is large enough to draw off water and pus from the bladder.

Special Cases producing Retention of Urine.

1. Two cases of perforated duodenal ulcer, in which retention of urine was a most pronounced symptom, were youngish men, aged about thirty, who complained that they were unable to pass their water. This condition had come on suddenly two days before. In both cases I was called upon to pass an instrument, and the urine was drawn off from the bladder. In both cases the patients died, and perforated duodenal ulcer was found. You remember with regard to perforated duodenal ulcer that pus may gravitate down behind the perineum and set up abscesses not only in the abdomen, but in the pelvis, and these may upset the musculature of the bladder. But whatever the cause, it is probable that retention of urine associated with abdominal catastrophes is more commonly associated with lesions in the upper rather than in the lower part of the alimentary tract.

2. How vesical calculus has caused acute retention of urine may be illustrated by the following case. The other day a female patient came up complaining of retention, for which a catheter was used. The diagnosis ought not to have been difficult, but there were circumstances in the way which prevented its being immediately made. I cystoscoped the patient and found lying behind the left urethral ridge a stone about half an inch long. I dilated the urethra and managed to extract the stone through the urethra with my index finger. The patient after the operation did not have any incontinence, and the "compressor urethræ" appeared to resume operations almost immediately after my operation. The stone, far from being symmetrical in every direction was found to have a largish upper end with a smaller pyriform lower end. I hand you round another specimen showing two calculi which were removed from the bladder of a man, one of which is curved in precisely the same way as the former calculus. I think, therefore, it may be the curved calculi that produce the obstruction.

But in this case, when one stone was not acting as a ball valve, the other one was, and the patient presented all the symptoms of acute retion of urine. And yet, when he lay quietly in bed he passed his water fairly well, because the stone had rolled away from the entrance to the urethra.

I want to draw your attention to a very useful local anæsthetic, iso-propyl hydro-cupreine, made by Messrs. Howard. Mr. Cooke and I have been trying it on out-patients, and I have been trying it upon some of my own private patients. I may say I am quite pleased with it as a local anæsthetic. A 2 per cent. solution is used for injecting into the urethra, and acts in about three minutes.

There are objections to the use of a local urethral anæsthetic, and I do not recommend its use under those circumstances where a false passage might be produced, but under certain conditions the use may help very much in the treatment of retention of urine.

A Case from Clinical.

THE following case is of interest, because in it, the connection between a chronic pyorrhœa and the numerous conditions which eventually contrived to kill the patient now under consideration, is unusually obvious. The episode, indeed, is like a Greek tragedy, in which the first scene is oral sepsis, the last scene is death, while the intervening acts serve to develop the theme and to show how the plot is carried on to its logical conclusion.

Case A., patient, æt. 52, clerk, admitted to Stephen Ward under Dr. Fawcett on November 11th, 1920.

This patient had suffered from pyorrhœa for many years, but the trouble had been accentuated during the last four. Seven years ago patient noticed that he was feeling weak and indolent and his doctor told him that he was suffering from anæmia. He went to live in Jersey for his health's sake, but the feeling of lassitude and malaise still persisted with remissions, in which patient was able to return to his desk. During 1913—1920 patient says that he lost four stones in weight. In the autumn of 1920, patient eventually went to see Mr. Hopson, who recommended him to come into hospital for investigation and treatment.

On admission.—Superficial inspection made it obvious that the patient was very anæmic and in a generally feeble condition. There was a slight malar flush; the hair over the outer half of the eyebrows was scanty and the skin of the hands was dry and inelastic. In addition, speech was slow and cerebration was delayed; it was thought that these stigmata denoted some degree of thyroid deficiency, and indeed, on comparing the patient with a photograph of himself taken ten years previously, the degree of facial deterioration was greater than could have been explained by the mere passage of time.

A routine physical examination brought to light a number of pathological conditions; these are described immediately below, but apart from *them* the patient showed no other abnormality at all.

Firstly, the teeth were affected with the most foul pyorrhœa that it has ever been the misfortune of the writer to witness. As the patient himself stated with pride: "When I lay down at night pus flows out of my mouth and stains the pillow."

Secondly, the blood showed a well marked secondary anæmia: hæmoglobin 55 per cent; erythocytes 4,900,000; colour index 6; white cells = 6,000.

Differential Count.—Lymphocytes 36·5 per cent.; polymorphs 51·2 per cent.; hyalines 10·0 per cent.; eosinophiles 1·5 per cent.; mast cells ·8 per cent. Slight poikilocytosis and anisocytosis were present; no nucleated red cells were seen.

Thirdly, the nervous system showed absent abdominal reflexes, absent knee and ankle jerks and an extensor plantar reflex. This suggested some degree of combined degeneration of the cord. Ankle clonus was absent. The heart showed no so-called hæmic bruit; the spleen and lymph glands were not enlarged and there was no urobilin in the urine.

On November 18th, 1920, the patient's teeth (twelve in all) were removed; there was no febrile reaction and under a course of arsenic and thyroid the patient's general and mental condition appeared to improve a little. The sockets healed up satisfactorily in the course of a few days.

Cultures from the root apex of a removed tooth grew streptococcus longus, staphylococcus aureus and micrococcus catarrhalis. A test meal showed a late rise of acidity and some gastric delay.

Blood count on December 9th, 1920.—Hæmoglobin 60 per cent.; red cells 4,700,000; colour index ·64.

Differential count.—Lymphocytes 45½ per cent.; polymorphs 42 per cent.; hyalines 9 per cent.; anisocytosis, but no nucleated red cells were seen.

On December 10th, 1920, after a considerable apyrexial period, patient's temperature suddenly rose to 104·4° and he became almost comatose and had incontinence of urine. His mouth was dry, the tongue was parched and dirty, the uvula was very œdematous and the teeth were covered with sordes.

Blood count.—Leucocytes 9,000 per cubic millimetre. A relative lymphocytosis was still present.

In a day or two some white membrane appeared on the patient's uvula, and fauces. "Streptococcal throat" was diagnosed. A swab demonstrated no diptheria bacilli, but staphylococcus aureus only.

Apart from the throat condition, however, there were no new physical signs to be found. Nevertheless, the patient, who hitherto had begun to improve again, developed otitis media and conjunctivitis (left side), on 18th and 20th of December respectively.

On the 20th patient seemed much worse, he spoke in a hoarse whisper and obviously was now suffering from laryngitis as well. Swabs from ear and eye grew staphylococcus aureus only.

On the 21st patient developed a temperature of 102·8°, and in the evening he suddenly collapsed and died of respiratory failure.

During his stay at Guy's there had been no loss of weight. At the autopsy there were found:—

1. Old healed apical phthisis.

2. Recent pulmonary œdema—possibly terminal—and most marked at the base.

3. Slight œdema of the glottis.

4. A normal heart, without "tabby-cat" striation.

5. No hyperplastic changes in the bone marrow of the ribs which was pale and fatty (and not red as one would have expected).

6. That both the suprarenals and thyroid were fibrous, small and atrophic.

7. That a culture of heart's blood incubated after death, grew an hæmolytic streptococcus.

8. An adenoma of the gall bladder—no larger than a hazel nut.

The spinal cord was removed for section.

I think that there can be little doubt that this severe secondary anæmia was due to prolonged absorption of toxins from the patient's very severe pyorrhœa alveolaris.

It seems probable, too, that the atrophy of thyroid and suprarenal were also due to the same intoxication.

Further, we have evidence of failure on the part of the red marrow. For in the first place there was a marked relative lymphocytosis—the sort of count one finds when the lymph glands and spleen are giving their normal contribution to the blood stream while the red bone marrow is not functioning properly. Secondly, when the patient fell a victim to septicæmia, a reaction in the nature of a relative and absolute polymorphonuclear leucocytosis was not observed. Thirdly, post-mortem the ribs were full of pale, fatty tissue—the kind of material one finds in an aplastic anæmia and not in one where regeneration of red cells is proceeding in a satisfactory way.

Another interesting point is the presence of combined degeneration in a severe secondary anæmia. One usually associates this condition with the so-called pernicious anæmia, though of course there is no reason why it should not appear in any disease in which the nutrition of the cord suffers.

In conclusion, it is not to be wondered at that a man suffering from primary toxæmia, with secondary anæmia and secondary insufficiency of thyroid, suprarenal and bone marrow should fall an easy victim to a severe infection of the throat; nor could it be expected that five weeks of hospital treatment would undo the mischief wrought by years of chronic septic absorption. I remember that the patient's wife described to me, how her husband had been told to have his teeth treated nearly ten years ago but to use her own words:—"he put it off time and again, he was that faint hearted." One cannot help thinking that had this patient been courageous enough to attend a dentist in the dim and distant past he might have found his valour the better part of discretion.

[I am indebted to Dr. Fawcett for permission to publish the case.]

M. M.

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K. Mullen, 14, Florence Road, Stroud Green, N. 4.

W. F. McAlpin, 19, St. John Street, Manchester.

W. A. Maggs, Riversford, Northam, North Devon.

Mr. G. T. Mullally, 10, Welbeck Street, W. 1. Tel.: Hop 2910.

Frank Cook. Telephone: Victoria 1268.

D. M. Desai, Raja Bahadur Motilal Mans., Apallo Street, Fort, Bombay.

Papers by Guy's Men.

W. H. Ogilvie, M.A., M.Ch., F.R.C.S., Two Unusual Cases of Small Intestine Obstruction.—*Lancet*, January 15th, 1920.

A Case of Stokes Adams Disease occurring in a Soldier.

THE following notes may be of interest, as this disease, rare at most times, is scarcely ever found amongst soldiers. The man affected had led a very active life. The symptoms came on very suddenly, and the case terminated rapidly.

Sergt. S., aged 43 years, was admitted to British Station Hospital, Secunderabad, complaining of fainting attacks and pain over the heart.

Previous History.—He had a long service in the army, with a very fine record in the war, being in charge of the battalion stretcher bearers all through the campaign, and gaining the D.C.M., M.M. and Bar. He stated that he had always enjoyed good health. He admitted that he had had gonorrhœa, but denied syphilis. His medical history sheet was not obtainable until after his death, when it was discovered that he had numerous entries, first for rheumatism, and, later, several times for syphilis. Late in 1918, he was gassed, and he stated that he had never really felt fit since.

History of present illness.—He stated that about a month ago he was playing cricket for the battalion, and made a few runs. He felt a bit exhausted, and, when he got home, he had a slight fainting attack. Since then, he had been rather "off colour," and had not been taking his food well. On being questioned, he stated that he used to get rather breathless when going upstairs. I had seen the man personally a couple of days before admission, just after he had climbed a steep flight of stairs, and noted at the time that he looked rather out of breath and a bit cyanosed. He stated that on the night before admission he was sitting in his quarters talking to his wife, and that "he kept on having turns," in which he said "he lost himself."

Condition on admission.—The patient was seen in bed. He was lying down, and did not give one the appearance of being distressed at all. His colour was not very good, but he could not be described as being cyanosed. He gave his history quite clearly. The first that I noticed about him was the extreme slowness of his pulse,, which was only 28 to the minute. It was of a curious consistency, being very forcible and slow, somewhat simulating a "water hammer pulse," but without collapsing again after each wave, the artery remaining full.

On examination, his chest moved well, and was normal to percussion, with the exception of an increase in the area of cardiac dullness, which extended to an inch external to the left nipple. The lungs were normal. On auscultation of the heart over the apex beat, a loud blowing systetic bruit was heard, which practically replaced the first sound. This was traceable out to the axilla. In the second right intercostal space, a blowing, aortic murmur could be heard.

He soon became somewhat collapsed, and strychnine, gr. 1/60th, was given hypodermically. This was followed almost immediately by two or three convulsions of an epileptiform character, during which the patient began to breathe rapidly and start twitching his face and limbs. These convulsions lasted from ten to twenty seconds. During the attacks, the radial pules could not be felt. This led me to suspect a cerebral hæmorrhage, but the attacks passed off and paralysis ensued. At the commencement of each convulsion, his face became pale, and, as the fit passed off, a wave of colour spread over his face. It was then noticed that there was a marked pulsation in the neck of the right jugular vein, and the rate of this was greatly in excess of the radial pulse, the ratio being 80 to 28. He continued to have convulsions every two or three minutes, and it was noticed that between the attacks he talked quite reasonably. The radial pulse would then suddenly stop; he would become pale, convulsions would occur, and then pass off. His colour would return and he would then continue talking.

On auscultation of the chest during an attack, loud bubbling rales could be heard all over both lungs, and there was a "death like" rattle in his throat. Oxygen was administered, but with no beneficial result. Hot water bottles were applied to the left side and to the feet, and champagne was given in small sips. His condition improved, and the convulsions ceased. He was given only fluid diet, which was administered in small spoonfuls at a time. He had a comfortable afternoon, and no return of the convulsions, and slept on and off for the remainder of the day.

Second day.—At 2.30 a.m., he had another attack of convulsions, and complained of cardiac pain and faintness. His colour was bad and he became cyanosed. With oxygen and hot foments to the left side, the condition improved, and he became fairly comfortable, sleeping at intervals. He had another attack at 6.30, and three more attacks during the morning, and it was noticed that the radial pulse was becoming slower, dropping to 14 beats per minute, whilst the jugular pulse increased to 86. He dosed off at times, and waked with a start, and complained of bad dreams. He spent a comfortable afternoon, taking nourishment well. Patient had a very bad night, with numerous convulsions, which became more frequent, and he became delirious at times.

Third day.—During the morning, his pulse ratio altered markedly. After two convulsive attacks the radial pulse increased to 50 beats per minute, but dropped again soon after. It was noticed that it always increased in rate just after an attack. He

had attacks almost continually all the morning up to 3.15 p.m., the radial pulse dropping gradually to 20, and the jugular remaining at 80. Atropine, gr. 1/200th, and digitalin, gr. 1/100th, given, but with no effect. The remainder of the day was fairly quiet, with occasional attacks.

Fourth day.—The next day, at about 11 a.m., the pulse ratio showed a marked improvement. The radial pulse improved both in rate and volume. There was scarcely a couple of beats difference between it and the jugular pulse. The patient felt very much more comfortable, and the bruits were not nearly so marked. This lasted until about 5 p. m., and one was hoping that the ventricles were becoming educated to beat on their own at a decent rate. However, he then had an attack of vomiting, followed by a bad attack of convulsions. He was given digitalin, gr. 1/100, which appeared to relieve him, and he slept.

Fifth day.—Next day, retching and vomiting increased, and he could keep nothing down. He began to get very irritable. A large number of moist, bubbling rales could be heard over both lungs, especially at the bases, but no consolidation was made out.

Sixth day.—Condition the next day was much about the same. Irritability was more marked. Vomiting severe. Complaining of pain in the pit of the stomach. He coughed up blood stained rusty sputum. No signs of consolidation of the lungs, but signs of hypostatic congestion. He had two attacks during the night, during which he stopped breathing, and the pulse was imperceptible. Oxygen and artificial respiration were administered. At 12 midnight he had some rest from vomiting and slept a little. Respiration got very rapid, patient rapidly sinking. He again stopped breathing. Oxygen and artificial respiration again brought him round. Two or three more continuous attacks occurred, and he passed away on the seventh day of admission.

A post-mortem was done, and the report is as follows:—

The thorax was opened by removing the sternum and costal cartilages. There was some slight adhesion of the pleura at the base of the right lung. The œsophagus contained a thick glairy mucus. On washing this away, the wall was found to be congested. The trachea was opened and contained frothy blood-stained mucus. The bronchi were congested, and, on squeezing the lungs, blood-stained mucus poured out. The lungs were engorged with blood-stained mucus, but no area of consolidation could be found, and portions cut from the bases floated easily in water.

The aorta was much dilated, and showed marked atheroma and ulceration of the walls, but no calcareous deposits. There was marked thinning of the wall at one place in the arch of the aorta. The pericardium was not adherent, and there was no increase in the amount of pericardial fluid.

The heart was greatly enlarged, weighing two pounds. There was great hypertrophy of the left ventricle, and great dilation of the right auricle and right ventricle. An incision was made into the left ventricle by passing scissors down through the aorta. The aortic valves were very much thickened and fibrous, more especially the septal cusp. There was a large organised clot of fibrin completely filling this cusp. The aortic ring was greatly dilated, thus causing incompetence of the valve. The walls of the left ventricle were greatly hypertrophied. The mitral valve showed no appreciable change, and there did not appear to be any dilatation of the ring. The left auricle was not dilated. The right auricle was very much dilated. The tricuspid valve showed no thickening of the chordæ tenelinal or the cusps, but there was considerable dilatation of the ring. The right ventricle was greatly dilated. Just below the septal cusp of the tricuspid valve, there was a firm tense swelling, protruding into the ventricle and corresponding with the lump to be left behind the septal cusp of the aortic valve. This lump is suggestive of a gumma, and appears to be invading the auricular ventricular bundle of His.

The liver was enlarged and very firm. The gall bladder was distended, and there were numerous adhesions to the lower surface of the liver, of the transverse colon and pancreas. On section, the liver showed marked "nutmeg" appearance, and was very engorged. The gall bladder was distended with blood-stained bile. The pancreas was greatly enlarged, and was adherent to the under surface of the liver. There was small hæmorrhage into the gland, and in the centre of the body a large cyst was found. The pancreatic duct was greatly hypertrophied. The kidneys were congested, and the capsule stripped easily. The spleen was enlarged and congested. The stomach was dilated and very much engorged, and there were some submucous hæmorrhages. Death was caused by failure of the heart, due to Stokes Adams disease.

A histological section, taken of the tumour found in the bundle of His, showed fibrous tissue only. No muscle fibres could be found at all.

D. C. SCOTT, Capt. R.A.M.C.

THE EDITOR will, at all times, be glad to consider articles or sketches, provided that they are accompanied by the writer's name and address, not necessarily for publication. The payment that the GAZETTE *can offer, is merely nominal. Authors who desire reprints of their papers should make their own arrangements with the printers when they return their proofs. All contributions to be addressed to the Editor, "Guy's Hospital Gazette," Guy's Hospital, London, S.E.*

Dentistry in the prehistoric Ages.

Pass List.

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University of Cambridge.

M.Ch. DECEMBER, 1920.

O. G. Morgan.

M.B., B.Ch. 2nd Examination.

ANATOMY AND PHYSIOLOGY.

C. K. Colwill.
F. E. Graham-Bonnalie.

M.B., B.Ch. 3rd Examination.

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PART II.—MEDICINE, PATHOLOGY AND PHARMACOLOGY.

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Report of Representative of Guy's Hospital

on the occasion of attendance at the

Annual Dinner of the University of Birmingham Dental Students' Society, 14th Dec., 1920.

At the Annual Dinner of the Birmingham University Dental Students' Society, Guy's Dental Society was represented by its Treasurer, in response to a kind invitation from the University.

After being received by the President, Mr. H. F. Humphreys, M.B., Ch.B., B.D S., L.D.S., we sat down to an excellent dinner, and afterwards enjoyed a very good programme of vocal and instrumental music.

During the course of his speech, in proposing the toast of "The Visitors," the late Dean, Mr. Malcolm Knott, expressed great pleasure at having Guy's represented at the dinner. He said that he considered it a splendid thing for schools with great traditions to come snd talk to schools who were making traditions. In proposing the toast of "The Visitors," he had much pleasure, he said, in coupling with it the name of "The Representative of Guy's Hospital." This met with fervent response. Dr. Lawrence Ball, Lecturer in General Medicine to the Dental Faculty, answered the toast in a most entertaining manner, and afterwards the President called upon the representative of Guy's, who was received with sincere enthusiasm. Alluding to a remark made by the Dean of the Dental Faculty that Colonial Students had commenced to arrive, our representative spoke of the keenness of a large number of Colonial Students from all over the Empire at Guy's, dental members of whom had received international honours at Rugby football. This met with tremendous applause. The hope was thereby expressed that such a representative hospital from the South, in meeting the Universities of the Midlands and the North, was helping to cement the brotherhood of present students and qualified members of the profession.

The following day was spent in an interesting tour of the Dental and Medical Faculties and the University Clubs' Union.

A successful process of casting inlays by centrifugal force was seen and a visit paid to the wonderful Humphrey's Museum of Comparative Dental Anatomy, which is claimed to be the most complete in the world. One only wishes there was one as fine anywhere in London.

In expressing the thanks of the Hospital to the President, Hon. Secs., and Committee, for the warmth of their hospitality, one wishes to say how much we appreciate the signal and distinct honour that has been paid to our Hospital and Society.

Reviews.

Medical Examination of Airmen. By Maublanc & Ratie, London. (John Bale, Sons & Danielsson, Ltd.). Price 3s. 6d.

I have read this little book from cover to cover with great interest. I find nothing in the book which is not absolutely sound. It will form a very useful guide to the civil medical practitioner in the matters which have to be taken into consideration by Officers of the Royal Air Force Medical Service in determining fitness or otherwise of flying personnel; and it is in this light rather than as a professional text book for those Officers that the book should be regarded. It will be found particularly interesting to those Medical Officers who have been associated with the development of the Royal Air Force Medical Service, and who remember that in the days of the old Royal Flying Corps, no specialised tests were applied to flying candidates beyond those of strict physical examination. In the early days, the problem to be solved by the Medical Officer was the selection of a series of specialised tests for the purpose of determining fitness for flying. In this connection it is interesting to observe that our friends and allies worked on precisely similar lines. As the book under review shows, they made the same enquiries into Family History. They insisted on the same high standard of fitness in respect of respiratory, circulatory, and nervous systems, vision, and auditory apparatus. In those early days, the object of our search was to ascertain which of our many tests had a really important bearing on fitness for flying, and which, however, physiologically interesting, could be discarded as possessing no determining influence.

Our Allies agree as to the necessity for absolute soundness of heart, lungs, and nervous system as a fundamental qualification: but if the methods of examination described represent their considered opinion, it would appear that some tests which were regarded as of determining importance, by us, are not mentioned; for example; Although they recognise the burden which flying places upon respiration, there is no mention of anything resembling our breath holding tests. In the investigation of the abdominal organs, examination of the abdominal wall is mentioned, but nothing is said about the relationship which exists between the tone of the abdominal muscles and of the alimentary canal, nor is "splashing" mentioned as being of value in its determination, moreover, they insist very strongly on the importance of chronic dyspepsia and its influence in producing cardiac arthythmia and nervous symptoms, nothing whatever is mentioned as to the supreme importance of the dental condition in the production of this condition.

The examination detailed for the nervous system is practically the ordinary routine investigation but whilst recognising the importance of trauma of the head, nothing is said of the effects of crashes, and the special traumatic neurasthenia which they say frequently produces a fruitful source of "P.U.P." (Permanently unfit Pilot). It is also interesting to note that in the examination of vision nothing is said of hereophoria or of the methods for its detection:

In the aural examination some attempt is made to produce a uniform sound test by means of Itard's Acoumeter, a method which seems less practical than a whisper and less scientific than that in which auditory acuity is expressed in terms of electrical resistance. Many of the tests of the auditory apparatus mentioned in this book were tried and abandoned in this country as being of doubtful utility except in cases where special investigation was required, for example the post rotatory mystagmus. No mention is made of the vertigo produced by eustachian obstruction which has been investigated in this country and in which it has been found that unequal or unilateral eustachian obstruction causing unequal tympanic ventilation, thereby produces a differential intra-tympanic pressure which induces vertigo especially during rapid changes of altitude.

It is also interesting to observe that the apparatus employed for the investigation of reaction time resembles, but is not nearly so thorough as that advised by an old Guy's man (the late Dr. L E. Stramm).

In this country in addition to the duty of selecting the most perfect types for flying, it is realised that if the trained pilot is to continue efficient, he must be under the constant and careful supervision of Medical Officers who are trained in the special requirements of the flying man and who possess the temperamental qualifications which enable them to maintain constant and intimate relations with the pilots under their care. The terms of intimacy on which Medical Officers live in mess with their charges, provides them with invaluable opportunities of judging from day to day the whims, peculiarities or errors, in the mode of life of the officers under their care, and to exercise benevolent supervision, over and above the routine examination required by regulation.

Last, but not least, in discussing the measurement of fatigue, it is noted that nothing appears to be known of the remarkable bearing of discrimination placed in the hands of the Royal Air Force Medical Officers by Flack's

Fatigue Test, which is justly recognised as being the most valuable test we possess.

The book may be regarded as a thorough exposition of the responsibilities and duties of the Medical Officers in selecting suitable candidates for training as flying officers and its perusal is recommended to all those who are interested in this subject.

Hygiene. Specially intended for those studying for a Diploma in Public Health. By W. WILSON JAMISON, M.A., M.D., (Aberd.), M.R.C.P., D.P.H. (Lond.) and F. T. MARCHANT, M.R. San. I. Student Synopsis Series. (Messrs. J. & A. Churchill, London, 1920) Price 18s.

The D.P.H. student will welcome the appearance of this volume, for it is the ideal examination book. Not too large, its pages embody all the essentials of a much larger book; and we should be inclined to describe it as being rather more than a synopsis of the subject. Therefore we may say at once that the authors have been quite successful in "their attempt to epitomise the views of accepted authorities." In general arrangement of sections the book differs little from others of its kind; but it is in the arrangement of subject matter that its strength lies. To the examination candidate the hallmark of its quality is "Tabulation," for every chapter has its important points enumerated in tabular form, thus presenting the subject in its most communicable and easily digestible form. The section on "Sanitary Law" is a good example of this mode of treatment.

And the good point noted—and one not usually found in text-books—is the inclusion in the body of the book of references to literature bearing direct relation to the subject in hand, thereby adding a further stimulus to the keener student.

In a book primarily theoretical in nature, it is surprising, and all the more pleasing, to find such a remarkably good chapter on "Practical Chemistry," where chemical processes like Tidy's Process and Wanklyn's Process are described in definite figures and amounts and quantities are not left to the imagination of the student. To elucidate the arithmetic thereof examples are added. Also many details of pure practical value are included, thereby greatly enhancing the worth of the chapter.

Pyorrhœa Alveolaris in its Clinical Aspects. By D. A. Crow, M.B., Ch.B.Edin. (Messrs. Balliere, Tindall and Cox, London.) 1921. Price 6s. net.

We imagine that nearly all medical men realise now that the disease usually designated by the term "Pyorrhœa" is, to a greater or less extent, responsible for much sickness. The author in this little book thinks that the fact is insufficiently realised and he is quite certain that the only appropriate treatment is rarely advised early enough if at all. He is an enthusiast and a whole-hogger. Extraction is his motto. Conservative dental treatment, vaccines, ionisation and the like he regards with suspicion and distrust.

Certainly he puts a good case well, and we hope what he has to say will be read and pondered by doctors, dentists and the lay public for, as he points out, only by the intelligent cooperation of the patient with his medical and dental advisers can good results be obtained. For this reason he adds a very good appendix entitled an "Explanatory Pamphlet for Patients," in which the dangers of oral sepsis are clearly stated and the steps to be taken to cure and prevent it are explained.

Probably there are a number of doctors who will not be willing to go all the way with Mr. Crow but they, at any rate, will not refrain from joining in the crusade against oral sepsis, and they must welcome the appearance of this work as a stimulus to a therapeutic measure which can justly be placed under the heading of "Preventive Medicine." Personally, we are inclined to share the author's extreme views both as to the results and the cure of pyorrhœa. We remember a lecture by Dr. Hurst and Mr. Hopson about a year ago in which this question was discussed and as far as we can remember extraction was recommended for all cases in which, whether by X-rays or other methods, pyorrhœa was diagnosed, and symptoms were present for which it might account. Most of us have seen some striking cases of cures in the wards here following wholesale extractions. It is an unpleasant process, as Mr. Crow admits, but in bad cases, some exacerbation can be controlled by vaccination a day or two before extraction. This is probably the only value that the vaccine has in the treatment of pyorrhœa, but it is not mentioned by Mr. Crow. A good book and worth reading.

RESEARCH DEFENCE SOCIETY.

This Society has lately published four pamphlets of general interest. (1) Vaccination: by Mrs. Scharlieb, C.B.E., M.D., M.S. (2) The Prevention of Tetanus, during the Great War, by the use of Anti-tetanic Serum: by Surg.-Gen. Sir David Bruce, K.C.B., F.R.S. (3) The work of the Medical Research Committee: by Sir Walter Fletcher, K.B.E., F.R.S. (4) The Value of Experiments on Animals: Notes on Personal Experience: by Sir Leonard Rogers, F.R.S., I.M.S. Price two shillings the set. Apply to the Society's Secretary, 11, Chandos Street, Cavendish Square, London, W. 1.

Air Sickness. by René Cruchet & René Molinier, translated from the French by J. Rosslyn Earp, M.A., M.R.C.S. Published by J. Bale, Sons & Danielssen, Ltd.

The importance of a careful selection of airmen was amply shown in the early years of the war, and although much progress has been made in devising a satisfactory scheme of examination, there are still some medical and

physiological problems unsolved. The publication of the work of these French observers is therefore particularly opportune. The book deals mainly with the alterations in blood pressure associated with flying, and especially with those found after a rapid descent; the reaction of the blood pressure is different in fit and unfit men, and a useful practical test of fatigue is based on this. There is a valuable chapter at the end of the book dealing with the physical conditions which contraindicate flying.

So much of the book is devoted to questions of blood pressure that other considerations as to a man's fitness for flying are not considered as fully as would be desirable; in particular much more detailed information should be given on the tests used in England. The book, however, is interesting as a physiological study, and will assist those who have to judge a man's suitability for aviation.

Directions for a Practical Course in Chemical Physiology. By W. Cramer, Ph.D., D.Sc. (Messrs. Longmans, Green & Co.). Price, 4s. 6d. Interleaved, 5s.

There are two additions in this, the fourth edition, of this practical handbook. One is a section dealing with tissue respiration, a fundamental activity of the organism which is not usually treated in books on practical physiology. The other is a brief but very clear account of the balance between acids and bases in the organism. This is the only part of the subject which is treated theoretically, but it forms a very welcome addition in view of the increasing importance of this branch of physiology.

We think that the section on the chemical analysis of tissues is far too brief; if this section were expanded and treated more fully it would be of much greater use. As its name implies, this book is a manual for practical work and the student using it must bear this in mind. As a practical book it is concise and its convenient size adds to its utility; but some text-book on chemical physiology must be read in conjunction with the practical work if the experiments described are to be of any value. Explanations of the experiments are not offered, but the student is encouraged by questions set in connection with many of the experiments to seek the explanations in his text-book.

Interesting Cases in the Medical Wards

DR. HURST, DR. HUNT AND DR. SYMONDS—
Addison 3, ? Gummata of liver.
6. Ascending myelitis.
11. Congenital heart.
21. Addison's disease.
Mary 33. Cerebral tumour.

DR. CAMERON—
Miriam 8. Xanthoma tuberosum.

Notices.

NATIONAL HOSPITAL FOR THE PARALYSED AND EPILEPTIC.

Queen Square, Bloomsbury, London, W.C. 1.

POST GRADUATE COURSE IN NEUROLOGY.

January 24th to March 18th, 1921.

Syllabus of Lectures and Demonstrations.

JANUARY.

Monday, 24th.—2 p.m., Out-patient Clinic, Dr. Collier. 3.30 p.m., Lecture, Cerebro-Spinal Fluid (1), Dr. Greenfield.

Tuesday, 25th.—2 p.m., Out-patient Clinic, Dr. Grainger Stewart. 3.30 p.m., Demonstration of Ward Cases, Dr. Risien Russell.

Thursday, 27th.—2 p.m., Out-patient Clinic, Dr. Farquhar Buzzard. 3.30 p.m., Lecture Room. Demonstration of Cases, Dr. Taylor.

Friday, 28th.—2 p.m., Out-patient Clinic, Dr. Gordon Holmes. 3.30 p.m., Lecture, Cerebro-Spinal Fluid (2), Dr. Greenfield.

Monday, 31st.—2 p.m., Out-patient Clinic, Dr. Collier. 3.30 p.m., Lecture, Cerebro-Spinal Fluid (3), Dr. Greenfield.

FEBRUARY.

Tuesday, 1st.—2 p.m., Out-patient Clinic, Dr. Grainger Stewart. 3.30 p.m., Lecture, Headache. Dr. Collier.

Thursday, 3rd.—2 p.m., Out-patient Clinic, Dr. Farquhar Buzzard. 3.30 p.m., Lecture, Neuritic Affections of the Upper Limbs (1), Dr. Farquhar Buzzard.

Friday, 4th.—2 p.m., Out-patient Clinic, Dr. Gordon Holmes. 3.30 p.m., Lecture Room. Demonstration of Cases, Dr. Tooth.

Monday, 7th.—2 p.m., Out-patient Clinic, Dr. Collier. 3.30 p.m., Lecture, Old and New Afferent Systems, Dr. Kinnier Wilson.

Tuesday, 8th.—2 p.m., Out-patient Clinic, Dr. Grainger Stewart. 3.30 p.m., Lecture, Diagnosis of Cerebral Vescular Lesions, Dr. Collier.

Thursday, 10th.—2 p.m., Out-patient Clinic, Dr. Farquhar Buzzard. 3.30 p.m., Lecture, Neuritic Affections of the Upper Limbs (2), Dr. Farquhar Buzzard.

Friday, 11th.—2 p.m., Out-patient Clinic, Dr. Gordon Holmes. 3.30 p.m., Lecture, Cerebral Abscess. Mr. Sargent.

Monday, 14th.—2 p.m., Out-patient Clinic, Dr. Collier. 3.30 p.m., Lecture, Old and New Afferent Systems, Dr. Kinnier Wilson.

Tuesday, 15th.—2 p.m., Out-patient Clinic, Dr. Grainger Stewart. 3.30 p.m., Lecture, Acute Polyneuritis, Dr. Collier.

Thursday, 17th.—2 p.m., Out-patient Clinic, Dr. Farquhar Buzzard. 3.30 p.m., Lecture Room. Demonstration of Cases, Dr. Taylor.

Friday, 18th.—2 p.m., Out-patient Clinic, Dr. Gordon Holmes. 3.30 p.m., Lecture Room. Demonstration of Cases, Dr. Tooth.

Monday, 21st.—2 p.m., Out-patient Clinic, Dr. Collier. 3.30 p.m., Lecture, Hysteria and its Treatment, Dr. Kinnier Wilson.

Tuesday, 22nd.—2 p.m., Out-patient Clinic, Dr. Grainger Stewart. 3.30 p.m., Lecture, Diseases of the Cranial Nerves, Dr. Collier.

Thursday, 24th.—2 p.m., Out-patient Clinic, Dr. Farquhar Buzzard. 3.30 p.m., Lecture, Disturbances of the Vestibular System (1), Mr. Scott.

Friday, 25th.—2 p.m., Out-patient Clinic, Dr. Gordon Holmes. 3.30 p.m., Lecture, Affections of the Pituitary Gland, Dr. Grainger Stewart.

Monday, 28th.—2 p.m., Out-patient Clinic, Dr. Collier. 3.30 p.m., Lecture, Functional Nervous Disease and its Treatment, Dr. Kinnier Wilson.

MARCH.

Tuesday, 1st.—2 p.m., Out-patient Clinic, Dr. Grainger Stewart. 3.30 p.m., Lecture, Cervical Ribs, their Symptoms and Treatment, Mr. Armour.

Thursday, 3rd.—2 p.m., Out-patient Clinic, Dr. Farquhar Buzzard. 3.30 p.m., Lecture, Muscular Atrophies (1), Dr. Gordon Holmes.

Friday, 4th.—2 p.m., Out-patient Clinic, Dr. Gordon Holmes. 3.30 p.m., Lecture Room, Demonstration of Cases, Dr. Tooth.

Monday, 7th.—2 p.m., Out-patient Clinic, Dr. Collier. 3.30 p.m., Lecture, Disturbances of the Vestibular System (2), Mr. Scott.

Tuesday, 8th.—2 p.m., Out-patient Clinic, Dr. Grainger Stewart. 3.30 p.m., Lecture, Syphilis of the Nervous System (1), Dr. Risien Russell.

Thursday, 10th.—2 p.m., Out-patient Clinic, Dr. Farquhar Buzzard. 3.30 p.m., Lecture, Muscular Atrophies (2), Dr. Gordon Holmes.

Friday, 11th.—2 p.m., Out-patient Clinic, Dr. Gordon Holmes. 3.30 p.m., X-Ray Demonstrations of Cases, Dr. Russell J. Reynolds.

Monday, 14th.—2 p.m., Out-patient Clinic, Dr. Collier. 3.30 p.m., Lecture, Friedreich's Ataria, Dr. Saunders.

Tuesday, 15th.—2 p.m., Out-patient Clinic, Dr. Grainger Stewart. 3.30 p.m., Lecture, Syphilis of the Nervous System (2), Dr. Risien Russell.

Thursday, 17th.—2 p.m., Out-patient Clinic, Dr. Farquhar Buzzard. 3.30 p.m., Lecture, Occupation Neuroses, Dr. Saunders.

Friday, 18th.—2 p.m., Out-patient Clinic, Dr. Gordon Holmes. 3.30 p.m., Lecture, Disseminated Sclerosis, Dr. Hinds-Howell.

Mr. Armour and Mr. Sargent perform Surgical Operations on Tuesday and Friday Mornings at 9 a.m. or at such other times as may be announced.

Application should be made to Dr. Greenfield by those wishing to undertake Practical Pathology, for which a special fee is charged.

Fee for Post Graduate Course, £7 7s., which should be paid to the Secretary of the Hospital at the Office on entering for the Course. A special arrangement can be made for Students who can attend one day a week only.

Holders of the Fellowship of Medicine's Ticket will be admitted to the Post Graduate Course.

C. M. HINDS HOWELL.
Dean of Medical School.

Guy's Hospital Reports.

We beg to announce the early publication of the new issue (of Vol. 1. of the Fourth Series) of "Guy's Hospital Reports," under the General Editorship of Arthur F. Hurst, M.D., assisted by the Editorial Committee.

The "Reports" will be issued quarterly, single numbers, 12s. 6d. net. Subscriptions £2 2s. net, post free, for volume of four numbers. The contents of the first number are as under.

All Editorial communications should be addressed to Dr. A. F. Hurst, Guy's Hospital, London, S.E. 1, and all business communications to The Managers, Oxford Medical Publications, 17, Warwick Square, Newgate Street, London, E. C. 4.

CONTENTS:

Richard Bright and His Discovery of the Disease Bearing His Name. By Sir William Hale-White, K.B.E., Consulting Physician to Guy's Hospital.

The Intravenous Administration of Quinine in the Treatment of Malaria. By G. Newton Pitt, M.D., Consulting Physician to Guy's Hospital.

Ulcerative Colitis. By Arthur F. Hurst, M.D., Physician to Guy's Hospital.

Studies in Gastric Secretion: Introduction. By J. A. Ryle, M.D., Assistant Physican to Guy's Hospital. I. The Hypersecretory Curve and its Interpretation. By J. A. Ryle, M.D., Assistant Physician to Guy's Hospital. II. On the Effect of Water as an Excitant of Gastric Secretion, with Special Reference to its Applicability as a Test-Meal. By P. McG. Moffatt, G. O. Mitchell and A. T. W. Powell. (From the Physiological Department, Guy's Hospital). III. The Effect of Atropine and of Pilocarpine on the Secretion and Motility of the Human Stomach. By T. Izod Bennett, M.D., Assistant Physician to Middlesex Hospital. (From the Physiological Department, Guy's Hospital.)

The Influence of Nervous Unrest on Digestion in Infancy. By H. C. Cameron, M.D., Physician in Charge of the Children's Department, Guy's Hospital.

The New Psychiatry: Some Impressions of the Work of the Phipps Psychiatric Clinic, Johns Hopkins Hospital, Baltimore. By C. P. Symonds, M.D., Assistant Neurologist to Guy's Hospital.

The Quantitative Estimation of the Vibratory Sensation. By Edward J. Wood, M.D. (From the Medico-Neurological Clinic, Guy's Hospital).

Diaphragmatic Hernia. By R. P. Rowlands, M.S., Surgeon to Guy's Hospital.

Note on "Eventration of the Diaphragm," with Description of a Case of Unilateral Elevation of the Diaphragm with Heart Pushed Over to the Right, Caused by Dilatation of the Splenic Flexure. By Arthur F. Hurst, M.D., Physician to Guy's Hospital.

A Case of Traumatic Subdural Hæmorrhage. By W. H. Bowen, M.S., Assistant Surgeon to Addenbrooke's Hospital, Cambridge.

Alopecia Areata. By H. W. Barber, M.D., Physician in Charge of Skin Department, Guy's Hospital.

Notes upon the Relation of Tonsillar Infection to Certain Cutaneous Lesions. By A. M. Zamora, M.Ch. (From the Throat and Ear Department, Guy's Hospital).

Diagnosis of Acute Mastoiditis. By W. M. Mollison, C.B.E., M.Ch., Surgeon in Charge of Throat and Ear Department, Guy's Hospital.

The Monocord as a Means of Treating Unilateral Hysterical Deafness. By W. M. Mollison, C.B.E., M.Ch., Surgeon in Charge of Throat and Ear Department, Guy's Hospital.

Guy's Hospital Annual Ball.

Guy's Hospital Annual Ball will be held at the Grand Hall, Hotel Cecil, on Wednesday, Feb. 2nd. Murray Pilcer's Society Dance Orchestra. Hostess, the Viscountess Goschen. Dancing 9 to 3. Tickets, 25s. each (including supper and refreshments), can be obtained from the committee, Messrs. E. N. Glover, N. E. Kendall, L. K. Watson, R. F. H. Duncan, B. L. Laver, and

D. J. P. O'MEARA,
R. B. P. LANSDOWN,
Hon. Secs.

Change of Surname.

I, Louis Forman, heretofore called and known by the name of Louis Fogelman, hereby give public notice that by a Deed Poll, dated 30th day of December, 1920, and duly executed and attested and enrolled in the Central Office of the Supreme Court on the 3rd day of January, 1921, I formally and absolutely renounced said surname of Fogelman and declared that I had assumed and adopted and intended thenceforth upon all occasions to use and subscribe the name of Forman instead of Fogelman, and so as to be at all times called, known and described by the name of Forman exclusively. Dated 3rd day of January, 1921.

Signed, LOUIS FORMAN.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

The War Memorial.

SIR,—I see in the GAZETTE of January 8th, the question of the words on the War Memorial is again raised. I do wish to urge, once more, that the words should commemorate the "noble effort" made by Guy's (men and women), and it should not merely be a tombstone wording.

Like Dr. Withers Green I find the suggested words lack any inspiration—they are deadly cold! May I suggest that over the centre might be "To the glory of those of Guy's who did their part nobly in the Great War, 1914—1918." Along the top of the plinth on either side of the main arch:

"To the Honour of those who came through."
"To the Memory of those who died."

—Yours etc.,

ASTLEY V. CLARKE.

Lansdowne House, 19 Victoria Road, Leicester.
January 10th, 1921.

SIR.—In a recent number you published a drawing of the War Memorial. Everyone was pleased with it, and many expressed their appreciation of the trees being left in situ. However, the first thing that is being done towards the erection of the Memorial is to drag down the most prominent tree depicted in the drawing.

For those of us who are obliged to live in the sordid and, at times, revolting environment of Bermondsey, the trees in the park have been some solace. During the recent building operations, many of our old friends have had to bite the dust, and we accepted the inevitable in silence. But this last tree killing exhibition was apparently not inevitable. May I express the hope that the few trees left in the park will remain untouched, unless they become a danger to the public or a bar to progress.—I am etc.,

RESIDENT.

Guy's Hospital, London, S.E. 1.

Guy's Hospital, 1921.

PRIZE EXAMINATIONS.

Competition for the undermentioned Prizes will take place on the following dates:—

Junior Prizes for General Proficiency.—Wednesday, March 9th, 10—1, Elementary Anatomy; Anatomy; 2—5, Physiology. Tuesday, July 5th, 10—1, Histology; 2—5, Elementary Anatomy. Tuesday, December 6th, 10—1, Elementary Anatomy.

Michael Harris Prize in Anatomy.—Wednesday, March 9th, 10—1. The date of the Practical Examination will be announced later.

The Wooldridge Memorial Prize in Physiology.—Wednesday, March 9th, 2—5. The date of the Practical Examination will be announced later.

Beaney Prize in Pathology.—Monday, May 9th, 10—1. The date of the Practical Examination will be announced later.

Treasurer's Medals.—Tuesday, June 7th, 10—1, Surgery; 2—5, Medicine. Wednesday, June 8th, 10—1, Commentary on a Case in Medicine; 2—5, Commentary on a Case in Surgery. Thursday, June 9th, 10—1, Clinical Examination in Medicine. Friday, June 10th, 10—1, Clinical Examination in Surgery; 2—5, Operations.

Golding-Bird Gold Medal and Scholarship in Bacteriology.—Thursday, March 10th, 10—1, Paper; 2—5, Practical. Friday, March 11, 10—1, Vivâ Voce.

Hilton Prize for Dissections.—The date of this Examination will be announced later.

The Examinations for *Open Scholarships in Arts and Science* will be held on September 20th, 21st and 22nd.

DENTAL PRIZES.

Third Year's Prize in Dental Subjects.—Monday, March 14th, 2—5, Dental Surgery. Tuesday, March 15th, 10—1, Dental Metallurgy. Wednesday, March 16th, 2—5, Dental Anatomy. Tuesday, July 5th, 2—4, Dental Prosthetics. Thursday, July 14th, 10—1, Dental Metallurgy. Tuesday, December 6th, 2—4, Dental Prosthetics.

Fourth Year's Prize in Dental Subjects.—Monday, March 14th, 2—5, Dental Surgery. Wednesday, March 16th, 2—5, Dental Anatomy. Friday, June 17th, 10—1, Dental Bacteriology. Friday, July 8th, 2—4, Dental Histology. Thursday, July 14th, 2—5, Operative Dental Surgery.

Fourth Year's Prize in General Subjects.—Tuesday, March 15th, 10—12, Surgery (including Surgical Pathology); 2—5, Anatomy. Wednesday, March 16th, 10—12, Physiology.

Prize for Operative Dental Surgery.—The examination for this Prize takes place in the Summer Session. The Regulations are given on page 44 of the Prospectus of the Dental School.

Newland-Pedley Gold Medal for Operative Dentistry.—The examination for this Prize begins in the Summer Session. The Regulations are given on pages 43 and 44 of the Prospectus of the Dental School.

Scholarship in Dental Prosthetics.—Wednesday, April 27th; Wednesday, September 28th.

No Candidate will be allowed to compete for any Prize unless he has given notice in writing to the Dean at least *fourteen clear days* before the commencement of the Examination.

The Services as a Career for Medical Men.

THE career of a doctor in either the army or the navy has always offered sufficient attractions to induce a certain proportion of newly qualified men to enter them. Before the war it was generally considered by those outside the services that military and naval medical men were not up to the standard of their civilian professional brethren. Although there are, of course, many notable exceptions, I am afraid that this was largely true—probably for two reasons. Firstly the career was one which offered advantages to the man who was not particularly keen; the sort of man who entered medicine through hereditary bias or for lack of any other alternative which was sufficiently attractive. Such a man saw in the army and navy the possibility of earning a competence at once, of having no very great strain thrown upon his intellectual equipment, and of being left in old age with, at any rate, a sufficient pension. The other determining cause of the inferiority of the war medical services was the lack of scope and opportunity that they offered to the really brilliant man. The young surgeon or young physician had no illusions as to the relative prospects of military and civil practice. The latter might mean a wait of many years before success and position were achieved, but the horizon was infinitely brighter. Fame, a good income, and the most intellectual form of work were all within comparatively easy reach. In the services the situation was less certain. There was much dull routine and often the possibility of following the line of greatest interest was denied. Moreover, it was no secret that the highest and best paid jobs carried with them duties that were mainly administrative. It can hardly be denied that before the war the best of the younger men did not enter the services.

This, then, was the position when the clouds of war burst over Europe in 1914. What did the war show us? The war showed that the position of the medical services was much as I have stated. But here let me make certain that I am not misunderstood. I do not wish anyone to think that the regular officers of the R.A.M.C. or of the Naval Medical Service did badly in the war. They did wonderful work. There were certain things that they could do better than anyone else. But, as the war progressed, no one could fail to notice that comparatively few of the more senior regular officers were found eligible for consulting work. I know that they were in the minority. Civilians of all ages and grades flocked to the services and the

regulars were completely snowed under. But nearly all the big posts involving purely medical or surgical work went to the newcomers. You could hardly expect an A.D.M.S., who had spent years in an office, to motor down to a C.C.S. and, say, plate a fractured femur. It was equally noticeable how the regulars retained all the administrative posts. Here was work for which their experience peculiarly suited them and right well did they administer. The D.M.S. was, as a rule, no great clinician. In many a field ambulance a medical officer would have valued his opinion on a point of differential diagnosis little higher than that of the Sergt.-Major.

Once more do not imagine that I am trying to run down the R.A.M.C. I am not. They were the victims of circumstances. Their purely clinical experience was on the whole less than that of their civilian colleagues, while their experience of army and navy administration was considerable and, in time of war, invaluable. After all the army and navy in times of peace are fairly healthy institutions. Only the fit are admitted. Those that fall sick provide experience only for such doctors as may for the time be attached to one of the hospitals. The chronics and incurables are discharged. There are, it is true, a few compensating advantages. Those medical officers who visit foreign parts get an opportunity to study tropical and other diseases of unique geographical distribution denied to their stay-at-home colleagues. The study and treatment of venereal diseases is made possible under especially favourable conditions. But still the fact remains that the material is limited. The men are young and fit. Disease is the exception and not the rule.

If the war taught a lesson of this kind the services were not slow to take advantage of it. For one thing the urgency of the problem that confronted the medical services demanded prompt attention and careful reorganisation. New methods in preventive medicine, bacteriological investigations on an unprecedented scale, the latest surgical technique, the treatment of unknown or hitherto unrecognised diseases and many other innovations had to be adopted. The scope of the medical services had to, and did, become more elastic, and now that the war is over and the services are returning once more to a peace time footing we may not unreasonably ask whether steps are being taken to maintain the high standard that the war forced upon them.

I think that an affirmative answer may safely be given to such a query but it is rather doubtful whether sufficient publicity is being given to the conditions of service now obtaining in the various services. At any rate the medical student has, at present, little encouragement from them because, while the conditions of civil practice are being continually brought to his notice, he gets barely any opportunity of becoming acquainted with the opportunities offered by the medical services of the army, navy and air force. The latter service is a very recently formed one and I doubt whether more than about one per cent., if as many, students realise either its existence or the nature of the work demanded of its medical officers. And it is of the R.A.F. medical service that I wish more particularly to speak.

Away in the Chiltern Hills where the heights run steeply down to lose themselves in the fertile Vale of Aylesbury lies the village of Wendover. Ten years ago it was a quiet and picturesque little township renowned for little save perhaps the variety and number of its licensed houses. A mile or so away is the House and Park of Halton, once the residence of the late Mr. Alfred Rothschild. The House and Park were acquired by the Government on the decease of its owner at the beginning of the war at a nominal sum and were at once converted into a large military camp. Huts sprang up like mushrooms on the hillsides, rifle ranges were dug out of the chalk and in a few months the hills re-echoed with the sound of musketry and the distant calls of bugles. The village itself adapted itself to its altered environment and strove nobly to maintain the dignity of a large military station. Had you visited it in, say, 1917 you would have found the suspicious eyes of two stalwart "red-caps" fastened upon you as you left the station. Dismissing the insistent solicitations of a number of taxi drivers (there wasn't even a horse cab before the war) you could have wandered into the village street, thronged with officers and "other ranks." Tea shops and refreshment houses would have met your eye on every hand. You might have dropped into the comfortable little bar-parlour of the "Shoulder of Mutton," now exclusively reserved for officers, and, if you had known this little Buckinghamshire village in happier days you would have wondered at its transformation.

It was the hope of many, not least those residents whose incomes did not depend upon local commercial enterprise, that the end of the war would see the village once more in "civvies." But this was not to be. The Air Ministry came along and took over the whole of Halton Park, House, camp and all, with a view to turning it into permanent headquarters—a sort of Aldershot—for the Air Force.

I knew Wendover well in the old days. Returning there shortly before Christmas I took the opportunity to penetrate into Halton House to call upon the officer in charge of the medical department, himself an old Guy's man. As a matter of fact I spent the best part of six hours there seeing everything there was to be seen and hearing from my guide all about the Royal Air Force Medical Service; and it is in the hope that what I saw and heard may be of some interest to readers of the GAZETTE, especially those who contemplate qualifying in the next year or so, that I am writing this article.

(To be continued.)

Guy's Hospital.

In accordance with annual custom the House-Committee publishes for the information of the Medical, Surgical, and Nursing Staff the following Tables showing the total number of Patients sent during the past year to Convalescent Homes and Sanatoria.

WARDS.	NUMBER OF PATIENTS. 1919	1920
Astley Cooper	8	13
Cornelius	9	15
Lazarus	35	40
Job	18	22
Naaman	29	32
Luke	37	54
Evelyn	15	16
Patience and Samaritan	9	11
Charity	55	48
Dorcas	34	69
Lydia	43	31
Martha	24	46
Eye Wards	9	9
Addison	35	29
Mary	30	10
Stephen	23	32
Esther	15	11
Queen Victoria	20	20
Clinical	—	2
Out-Patient Department	136	96
	584	606

The subjoined list gives the distribution of the Patients amongst the various Homes:—

Ascot Priory (Women and Children)		57
Merchant Taylors' Home (Bognor) (Men)		62
Metropolitan Convalescent Institution:—		
Bexhill (Women)	115	
Bexhill (Little Common) (Men)	45	
Broadstairs (Children)	90	
Walton-on-Thames (Men & Women)	34	
		284
Rustington Convalescent Home		46
Schiff Home of Recovery		55
		504

SANATORIA.

(Beds allocated free of charge to the Hospital by the King's Fund):—	
Devon and Cornwall Sanatorium	14
Kelling Sanatorium, Holt, Norfolk	6
Holt Sanatorium (Children)	3
	527

In addition to the above, 79 Patients have been sent to various places for convalescent treatment, principally in co-operation with the Charity Organisation Society, and the Invalid Children's Aid Association... 79

606

List of amounts received from Patients in the various Wards, and sums found in Ward Collecting Boxes, etc., for the year ending December 31st, 1920. The amounts received in the previous year are inserted for the purpose of comparison.

	Box Collections. 1920. £ s. d.	Special Donations. 1920. £ s. d.	Totals. for 1919. £ s. d.
Front Gate	8 0 0	—	5 4 11
Porter's Lodge	80 3 0	—	12 7 8
Out-Patient Dept.	53 19 2	17 19 0	58 11 4
Surgery	27 1 6	3 13 6	27 7 11
Dental Department	13 18 11	2 10 0	3 6 0
Light Department	32 10 0	40 0 0	36 10 5
Massage Dept.	149 12 0	1 11 0	119 14 3
Electrical Dept.	14 6 5	—	14 16 1
Matron's Office	2 4 1	—	—
WARDS.			
Addison	6 8 3	44 7 0	47 2 10
Astley Cooper	2 8 9	15 13 0	27 19 10
Bright	2 11 7	54 5 0	131 13 6
Charity	8 15 6	113 11 0	79 12 1
Clinical	1 17 0	4 0 0	1 11 7
Cornelius	0 18 7	10 19 0	21 17 6
Dorcas	21 6 2	262 1 3	79 12 1
Esther	4 11 0	95 6 6	80 10 9
Evelyn	4 15 4	108 17 0	11 16 4
Eye	12 4 7	138 18 0	27 2 9
Job	9 6 4	45 18 6	59 15 3
Lazarus	3 0 4	44 11 9	44 8 8
Luke	10 11 8	95 7 0	43 2 3
Lydia	8 14 0	149 0 6	96 9 2
Martha	7 17 6	134 9 0	86 19 0
Mary	1 5 3	65 2 6	44 13 6
Naaman	3 1 0	133 1 0	81 6 3
Patience and Samaritan	2 17 8	101 11 0	8 4 11
Queen and Victoria	9 3 0	236 4 0	102 9 10
Stephen	7 11 0	56 5 0	66 10 0
	£510 19 7	1975 1 6	1420 16 8

TOTALS.	1920. £ s. d.	1919. £ s. d.
Box Collections	510 19 7	344 11 9
Special Donations	1975 1 6	1076 4 11
	£2486 1 1	£1420 16 8

In addition to the above the following sums have been received from Patients in respect of Special Treatments during 1920:—

Light Department	100 0 9
Massage Department	132 14 6

Football.

GUY'S v. LONDON SCOTTISH.

With this match at Richmond on Saturday January 8th the Hospital commenced the second part of the Football programme. Not yet at full strength, one hopes that shortly a full side will be put in the field so as to prepare for the Hospital Cup Competition. We shall be severely tested again this year, one at least of the London Hospital sides is very strong and if victory is to come our way we must get into as fit a physical condition as training can make us. For the Senior and Junior Rugby Cup some 30 men have a chance of playing in the Finals. These 30 should, till after the Final is played, lose no time in making and keeping themselves at absolute concert pitch.

W. Olivier re-appeared at full back against the Scottish, and it is a matter of congratulation to notice that Graham-Davies is a reserve centre for Wales. Hospital football is well to the fore in the Welsh reserve list, M. G. Thomas the Bart.'s three-quarter being in that company. Van Heerden played on the wing to Steyn, on January 8th, and scored a couple of tries. He has plenty of pace and no one can truthfully accuse him of want of determination. It wasn't a very nice afternoon for football and I think most felt "after Christmassy," but that need not have so upset the gentleman who wrote in a Sunday contemporary on the the match, the day following. The Scottish, he seemed to think should have been pulverised (one must remember their two best forwards, C. M. Usher and G. H. H. Maxwell, were figuring in the Scottish Trial at Inverleith). We also would have been eaten almost, if we had had a decent side against us and so on; seems a pity to write it at all, because its unkind comment, so I won't pursue the subject; but after all I believe the game is primarily played because the players wish to play, therefore, firstly the game is played because of the players, next in consideration should come the payers and others who are present in a professional capacity needn't be unkind if the standard is not up to the pitch expected.

There were a great many penalties and early in the game Neser had a shot at goal. Daneel showed particularly good form and was, after some twenty minutes play, rewarded with a try which was not converted. Neser also missed converting a try which Van Heerden scored, after the Guy's backs had handled with much cleverness. These two tries were all the advantage we could claim when the interval took place.

Well led by Doherty, who never failed to put any amount of ginger into the game, the forwards played better and Reitz managed to gain a try; in attempting to convert this score, Van Schalkwijk hit the crossbar. Then, after much passing behind the scrum, Van Heerden got another try. Guy's finished winners by 4 tries (12 points) to nil. Honestly we should have done much better. Its no good making excuses, we do want more hearty going for the line.

Guy's team.—W. J. Olivier, H. Van Heerden, C. L. Steyn, P. K. Albertyn, A. Daneel, F. Bekker, J. G. Van Schalkwijk, W. D. Doherty, F. W. Reitz, A. Marais, E. E. Neser, H. Van Zyl, A. H. Shelswell, R. Macintosh, W. H. Taylor.

Hockey.

GUY'S HOSPITAL v. WALLINGTON.

The ground was heavy at Forest Hill on Wednesday, January 12th, when Guy's beat Wallington by 6 goals to 3, and the play was consequently inclined to be scrappy.

Guy's were superior in the forward line and led at half-time by four goals to one, B. M. Tonkin having scored twice and D. C. Eglinton and L. E. Owen once each, whilst A. Metcalf scored for Wallington. In the second half Eglinton added another goal, and J. V. Schollum also scored, Wallington having added two goals by A. Metcalf and D. B. Chartres.

Some good saves were effected by the goalkeepers of both sides, but Wallington, whose half line was good, were weak forward, with the exception of Metcalf. Our forwards played very well together—J. V. Schollum and W. S. Hunt being especially good on the right—and H. Slater worked hard at centre half.

Guy's team.—R. Schofield, W. F. Hurdle, W. Spurrell, G. R. Ford, H. Slater, S. C. Olver, W. S. Hunt, J. V. Schollum, B. M. Tonkin, D. C. Eglinton and L. E. Owen.

GUY'S v. CHARLTON.

Guy's had most of the play on Saturday, January 15th, when they easily defeated Charlton at Forest Hill by seven goals to one.

J. V. Schollum scored no less than five goals, and B. M. Tonkin and F. E. Graham-Bonnalie were responsible for the remaining two. Charlton's goal was scored by Blythe.

Guy's team.—C. T. V. Baugh, W. Spurrell, W. F. Hurdle, D. C. Eglinton, H. Slater, S. C. Olver, W. S. Hunt, J. V. Schollum, B. M. Tonkin, F. E. Graham-Bonnalie and E. G. Smallbone.

Guy's are drawn against Middlesex (the holders) in the first round of the Inter-Hospital Cup, which is to be played on Wednesday, February 2nd.

Birth.

OGILVIE.—On January 12th, to Magdalen and Heneage Ogilvie, M.A., M.Ch., F.R.C.S., of 27, Hamilton Terrace, a son.

Marriages.

DESAI—SETALWAD.—On the 19th December, 1920, Mr. D. M. Desai, L.D.S., R.C.S.Eng., to Kusum, second daughter of Sir C. H. Setalwad, Kt.

EVANS—COOK.—On January 18th, at High Barnet, Henry William Evans, M.D., to Evelyn Constance Cook.

ED.—M. E. S.

GUY'S HOSPITAL GAZETTE.

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Passim.

IF Mr. Sampson Handley could have seen the pile of letters that reached us on Monday morning he would have realised that if we had forgotten him for the moment he was still remembered by a host of old friends and colleagues from Guy's. We offer him our apologies for suggesting that Dr. Bennett was alone among Guy's men on the staff of the Middlesex Hospital.

WE have been asked many questions recently about the War Memorial, which is now progressing very rapidly. The chief concern of our interrogators has been the ultimate fate of the porter's lodge and the present gates and railings. As far as we know it is the intention of the authorities to leave the railings and, presumably, the lodge too, in their present situation. The prevailing opinion seems to be that they should both be removed, so that the War Memorial shall be the real barrier between the Borough and the Hospital. We share this opinion ourselves. It seems rather ridiculous to have the present unsightly railings doing duty as a boundary line with a purely ornamental duplicate only a few yards away. The extra space that would be added by the demolition of the railings would set the memorial arch off, and it would be seen from the outside at much greater advantage. At present the view is obscured by these railings which no one can consider beautiful. Their removal would necessitate certain modifications or rather additions to the present design of the Memorial. Railings of some sort would have to be inserted in between the pillars but these, if carefully chosen, would not damage its appearance, indeed, really good iron railings would look very well. New gates would be an advantage but they would of course be expensive. At any rate, the proper place for the gates is clearly between the two central columns of the arch and not where they now stand.

With regard to the lodge there would probably be more difficulty. There must be a porter's lodge but it seems a pity that it should occupy the exact situation that it does at present and that, in architectural design, it should be so out of sympathy with the Memorial. If the railings came down it would have to be moved in order to put it inside the gates and, if this were ever done, the opportunity might be taken to improve both its position and its appearance.

AT the time of writing the First General Business Meeting of the University of London Union Society has not been held. The date fixed is Friday, February 4th, so it is useless for us to encourage hospital men to attend. We

hope, however, that Guy's will not have been unrepresented. We printed, some time ago, the circular letter which was sent out to invite members of the University to join. At the risk of repeating ourselves we should like once again to draw the attention of our readers to the fact that the Union is being formed and that it is apparently meeting with a considerable degree of support from all connected with the University of London. Oxford and Cambridge have long had Unions, but there is so much social activity in these Universities apart from them that their absence would not be seriously noticed except, perhaps, by a small band of enthusiastic orators and would-be Prime Ministers. The University of London has practically no social or corporate life apart from that provided by its Colleges. It is true that the Colleges are numerically much bigger than those of Oxford and Cambridge, and it is therefore possible for their members to carry on athletic and social activities to an extent denied to the smaller Colleges of the older Universities. We think, however, that the undergraduate members of London University are right in attempting to instil a more cohesive spirit into their various constituent Institutions and Colleges, and we have every sympathy with their effort to form a Union Society which shall be the centre of undergraduate life.

The idea is to get suitable premises, very probably on the Bloomsbury site, and to use them for administrative headquarters and for a Social Club. One of the great disadvantages of a University like London is that the undergraduate members tend to get into watertight compartments. There is no free interchange of ideas between men of different ideals and different prospects. This especially applies to the Hospitals. Personally we consider that the Union will be perhaps more valuable to the hospitals than to any of the numerous colleges that go to form the University. A medical student meets no men of his own age except those engaged in his own particular branch of study. He works all day with medical students, he eats with medical students, he plays with medical students, and very probably he digs with medical students. That is not the sort of environment to produce the wide outlook on life essential to a medical man. How different to Oxford and Cambridge! There (unless he be at Caius) the medical student only meets his co-workers in work hours. In his spare time he meets and talks with English, classical, historical, mathematical, and a host of other sorts of students. This cannot be in London, but the Union will do great work if it draws together men of diverse interests. Medical students have an unenviable and, we think, entirely undeserved reputation. Why? Merely because they herd together in their respective Hospitals and no one ever sees them except under the exceptional and exuberant conditions of a Cup tie or other similar function. A few may penetrate to a University debate or, if they have a friend there, into another College. The majority do not even know where the other Colleges are, much less the nature of their inhabitants. We hope that the hospitals will not be slow to make use of a project which offers them great advantages of a sort that they have not, as yet, had the opportunity to test.

To those who join at once is offered the privilege of "original membership." This means that the entrance fee, which is certain to be imposed later on, will not affect them, and they will be admitted without the necessity of being formally proposed and seconded. Forms of application may be had from Mr. Winston, in the Library. We shall report the further progress of the Union in the "Gazette," so that those who feel hesitation may learn that they are not asked to throw in their lot with a "dud" concern, but with a real, live, active student organisation, such as has not been seen in London before.

Our plea for the thining of the forest, more usually referred to as the Park, seems to meet with little sympathy. A correspondent sends some verses this week in defence of the trees and we have been asked, with reference to our remarks a fortnight ago, which wards are deprived of light by excess of foliage. To our poetical correspondent we can only say that we are in entire sympathy with Miss Levy's verses. We should not dream of suggesting a wholesale removal of all the plane trees. As trees we admire them as much as any one, we merely think that their number is excessive. With regard to the wards, all those on the South side of the Surgical block suffer considerably, and the windows of the new Massage block are literally plastered with exuberant vegetation. The rooms in the North-West turret of the College are in perpetual obscurity during the summer months when the leaves are out. All past Wardens will bear witness to this. Half the "sordidness" of Bermondsey is due to its dingy atmosphere, but every one seems to conspire to perpetuate it. Why?

Our lay contemporaries are much concerned with the so-called epidemic of Encephalitis Lethargica. A correspondent of one of the Sunday papers sought information about the "sleeping sickness" from a Ministry of Health expert, who is reported to have stated that the disease was almost certainly due to a microbe, as yet undiscovered, unlike that of beri-beri the African sleeping sickness! We anxiously await the comment of the medical correspondent of the *Times* on the amazing ignorance of the Ministry's officials! If only they had studied the "New Medicine."

We are very glad to publish this week a letter from a general practitioner thanking a House officer for sending him details of a case of his that had been under an operation in the Hospital. We are assured that medical records are a waste of time, but there is ample evidence that their value is realised by the profession. In a hospital where (reasonably) accurate records are available of every case it ought to be the rule that no patient is discharged without all details, at all relevant to the case, being sent to the private doctor. It must be not a little trying for a doctor to have a case sent back from hospital with no details save a highly inaccurate story from the patient himself.

Women Jurors seem to be firmly established. The medical profession have long recognised the value of women in certain spheres of public life, and we think the administration of the law is no less suitable an occupation for them than the supervision of the public health. The novelty of the innovation has led to much comment in the press, both pictorial and otherwise, and a few objections have been raised, chiefly, it seems, with a view to making legal capital in difficult cases. In a few years we shall think women jurors no more surprising than women doctors.

Once more may we draw the attention of our readers to the Musical Society's Concert on Tuesday next, suitable advertisements of which will be found in the Colonnade, College, and elsewhere? Tickets will be sold at the door for those who do not take the precaution of procuring them beforehand.

We offer our heartiest congratulations to Mr. Doherty on his being chosen to captain the Ireland XV against England on February 12th. We feel sure that, in him, Ireland has found the leader they needed; one who spares neither himself nor his pack, but plays and demands the same vigorous and ubiquitous game from kick-off until no-side. In spite of all the reservations which patriotism prompts, we wish him every success.

The Heart in Muscular Exercise.

Paper read at the Physiological Society's Meeting on Monday, 10th January, 1921, by
MR. J. A. CURRIE.

Mr. Chairman and Gentlemen,

I have noticed that it is a common practice, among readers of papers before this Society, to introduce their subject by a brief historical resumé; and their observations are as often as not derived from reference to Scripture. This precedent is not easy to follow when writing a paper on the heart, for apparently in ancient times this organ was considered to be the seat of the affections, or at any rate concerned with emotions of all sorts. Attractive as this aspect of the subject must be to many, it is not with this that I propose to deal to-day.

My object in choosing this subject has been twofold. In the first place, while "alcohol" is doubtless an intensely engrossing subject, with "sleep" a good second, one cannot but feel that there is a very large number of members of this Society whose interest in muscular exercise is practically unbounded. Apart from considerations of ordinary sports, have we not often seen the edifying spectacle of a gentleman feverishly purchasing a newspaper to see whether Capt. Coe's predictions have turned out to be true at last? And secondly, I have chosen this subject because it affords us one of the most beautiful examples of co-ordination, of delicate adjustment, and of efficiency, that nature can supply.

The essential requirement in order that muscular work may be satisfactorily performed, is an adequate supply of oxygen to the active muscles, and it is by the correlation of two systems, the circulatory system and the respiratory system that this requirement is satisfied.

The oxygen consumption of the active muscles may be regarded as a measure of the work performed by them, and it is found that an increase of oxygen-consumption during exercise runs parallel with an increase in pulmonary ventilation. Now in order that an increased pulmonary ventilation may be used to full advantage, two considerations are necessary. (1) The oxygen leaving the lungs must be almost as fully saturated with oxygen as during rest, and (2) the blood-flow to the tissues must be enough to ensure that these receive an adequate supply of oxygen.

It is with this second consideration that the heart is concerned. The rate of blood-flow round the body depends upon the output of the heart per minute, and other circulatory adjustments help this output to be utilized.

Krogh, in 1912, employing the nitrous oxide method of estimation, found that the output of the heart per minute rose from about 3 to 5 litres while at rest, to 8 or 9 litres during moderate work, and that during heavy work it became as much as 20 litres. Further, Lindhard, Mears, and Newburgh, using a bicycle ergometer to measure the external work performed by the subject, found that there was a linear relationship between the work performed and the output of the heart. Now this output per minute is the product of two factors, the output of the heart per beat, and the pulse rate. We shall deal first with the output per beat.

It is obvious that the heart cannot send out more blood than it receives, and if the output during exercise can be four or five times as much as that during rest, it follows that the venous inflow must be correspondingly increased. The increased contraction of voluntary muscles, and the greater range of respiratory movements, quicken the return of venous blood to the heart, thus leading to a greater diastolic distension and a greater output by the left ventricle.

Now there are two factors which may influence the filling of the heart in diastole. One is the rate of venous inflow, and the other is the rate and completeness of relaxation of the ventricular walls. This latter factor is not regarded by Starling or Bainbridge as of any importance, although Caskell has propounded the theory that the heart muscle possesses a variable diastolic tone, *i.e.*, the heart need not always fill to the same extent under the same venous pressure. This view of Caskell's is supported by Yardell Henderson and some clinical writers, but physiologists in general accept the view that the filling of the ventricles is solely dependent upon venous inflow, while this in turn is due to the pumping action of the muscular movements.

Now Starling has enunciated a law, known as the Law of the Heart, which states that the force with which the heart contracts is proportional to the initial length of its fibres. In other words, since the heart is a hollow organ, the contractile power of the heart depends on the diastolic volume. And as the ventricles are perfectly distensible during diastole, the force of the heart beat depends upon the venous inflow.

In man the law of the heart is not absolutely obeyed. Speaking theoretically, each increase in diastolic volume should so increase the force of the heart-beat that it completely discharged at each systole, the blood entering it in the preceding diastole, but this does not occur. As a result we have a gradually increasing rise in the volume of the heart until a balance between inflow and output is reached at a higher level. This dilatation

of the heart during exercise is a normal physiological process, and is only limited ultimately by the pericardium. We see, therefore, that the contractile force of the heart is influenced by it volume at the end of diastole. But there is another factor on which the force of the heart-beat depends, and this is the condition of nutrition of the heart's fibres.

The contractile power of the heart, for any given diastolic volume, varies with the nutritive condition of its fibres; and we thus see that a thick-walled ventricle is in a much more favourable position than a weak, thin-walled one. For while the muscular, thick-walled heart can contract sufficiently forcefully without a very large increase in diastolic volume, the thin-walled ventricle has to dilate much more to produce the desired effect. In fact it often has to dispense with the desired effect, since it cannot dilate enough, owing to the limits imposed by the pericardium. And this is where the pulse-rate comes in. A man with the weak, thin-walled heart of a sedentary person has to compensate for this lack of power, this poor output per beat, by an increased number of beats; or in other words, by an acceleration of the pulse.

We now come to consider the influence of the pulse-rate upon the output of the heart. As we have seen, the diastolic filling, and therefore the output per beat of the heart depend upon the pressure of the venous inflow, since the ventricular muscle is completely relaxed in diastole. Now as the venous inflow increases, a point may be reached in which the ventricles are fully distended, *i.e.*, have reached the limit of distension imposed by the pericardium, before the end of diastole. And if the venous inflow still continues, it will merely lead to an accumulation of blood in the great veins. Or, if it increases, it will merely fill the heart earlier in diastole than before. Krogh has called this "adequate" filling of the heart; and he has pointed out that if the venous inflow is small, an acceleration of the pulse-rate, while lessening the output per beat, scarcely increases the minute-volume at all.

On the other hand, if the filling of the heart is "adequate," that is if it occurs early in diastole, the pulse-rate and minute-volume will go up together. The venous pressure will rise if the blood flowing into the great veins exceeds in volume the accommodation offered it by the heart, and a rise in the pulse-rate will lower this again.

We thus see that the output per minute of the heart is the product of two things, the output per beat and the pulse-rate; and that the output per beat depends upon venous inflow, contractile power, and the duration of diastole. The venous inflow we have seen to be activated by the pumping action of the muscles, the contractile power depends upon the size and state of nutrition of the ventricles, and the duration of diastole depends upon the pulse-rate, whose regulation we will now consider.

At the outset of exercise the pulse quickens, owing to a shortening of the diastole, and it soon reaches a steady level at a higher rate. This initial acceleration is ascribed by most writers to loss of vagus tone, but C. Bourne considers that it is due both to this and rise in accelerator tone. His view is based on the fact that he administered, to a healthy subject, a dose of atropine sufficient to eliminate vagal inhibition. But the pulse-rate did not rise above 100 or 110, and any acceleration beyond this must be due to something more than loss of vagus tone.

This initial acceleration is due to nervous impulses reaching the vagus and accelerator centres in the medulla, from the highest centres, concomitant with the outflow of impulses to the voluntary muscles. Johansson, in 1893, arrived at this conclusion, namely that the initial rise in pulse-rate is due solely to nervous impulses from the higher centres. He found that when he induced passive movements in a rabbit's limbs there was no initial quickening, the psychical factor being absent. We are all familiar with the state of an athlete shortly before starting a race. His muscles are toned up, he is in a state of tension, his respiration and pulse-rate are quickened up. So we see that the very thought of exercise in enough to quicken our pulse-rate.

There are various factors concerned in the maintenance of this high pulse-rate, besides the continued outflow of impulses from the higher centres. One of these, as we have seen, is the rise of venous pressure. And the other is a rise in temperature of the blood. Owing to the greater intensity of the metabolic activities of the body, the temperature rises, and causes an acceleration of the heart. But this is of subsidiary importance.

The adrenaline theory, so ardently supported by Cannon, holds that during exercise a greater flow of adrenaline exercises the same effects as stimulation of the sympathetic system. The vaso-constriction in the splanchnic area, the high pulse-rate and the dilatation of the coronary vessels are ascribed by Cannon to the effects of adrenaline. And there is certainly a great deal to be said for the hypothesis. It seems to be a wonderful provision of nature that adrenaline, which, according to Cannon, stimulates the heart to an increased vigour of contraction, and a greater output, should at the same time arrange for the nutrition of the heart, by dilatation of the coronary vessels. And the marked vaso-constriction in the splanchnic areas also allows for the passage of more blood into the active muscles.

(While on the subject of vaso-constriction in the splanchnic areas one might mention, in passing, that it is this which makes exercise so difficult and possibly injurious after a heavy meal; since the absorption of food-stuffs requires a vaso-dilatation in the splanchnic area. But this is by the way.)

To return to the adrenaline theory:—We know that Cannon holds that every state of excitement, and also concentration which precedes exercise, causes the secretion of adrenaline into the system. Stewart and Rogoff, however, hold that the secretion of adrenaline exercises a continuous, and not a spasmodic effect, and Bainbridge, in his monograph on muscular exercise, advances the view that the rise in pulse-rate and vaso-constriction might be explained equally well by a reference to impulses from the higher centres. He believes that the impulses which go to the skeletal muscles are accompanied by impulses to the visceral sympathetic system, as we have seen, and does not lay great stress on the importance of adrenaline.

It is a common knowledge that a rugger team is not nearly so effective as it should be when it lacks supporters. And any player will tell you that he sometimes gets excited, and plays a greatly improved game when he hears his crowd cheer, even though he has previously felt nearly "done." This sudden access of energy in moments of great stress, might certainly be ascribed to a sudden outpouring of adrenaline which accelerates the pulse and dilates the coronary vessels, leading to better work by the heart. But Bainbridge prefers to regard the psychical factor as predominant. This, of course, can, by causing a stimulation of the sympathetic system, answer the same purpose.

While dealing with pulse-rate it is interesting to note that in the initial stages of exercise the muscles need an extra supply of oxygen before either the "muscular pump" has had time to work, or enough CO_2 has been formed to cause a rise in C_1 and stimulate respiration. And here the nervous factor steps in. As usual, when speed is desired, a nervous impulse can effect the desired object more frequently than either a mechanical or chemical factor.

There is a clear correspondence between the intensity of muscular work performed, and the frequency of the pulse. In the first place the outflow to the skeletal muscles is accompanied, as I have, I fear, constantly reiterated, by impulses to the medullary centres which control the pulse-rate. Secondly muscular work—again I repeat myself—increases the venous inflow, raises the venous pressure, decreases vagus tone, and so accelerates the pulse.

To take the two factors—output per beat and pulse-rate—and correlate them is now simple. At the outset of exercise the heart dilates to maintain output against the higher arterial pressure. Acceleration of the pulse has little effect upon the output per minute until the venous inflow increases. Then the diastolic volume becomes larger, the heart's contractile force increases, the minute-volume increases, the pulse-rate goes up, and the output per minute soon varies directly with the oxygen consumption, that is, with the intensity of exercise. There are wonderfully accurate adjustments which, as we see, arrange that intensity of exercise and the output of the heart go hand in hand. No man, therefore, can be an athlete unless he possesses a powerful and well-nourished heart.

In order to attain to this much desired end, training is essential The process of training consists essentially of regular and progressively increasing exercise. Other factors are of less importance. I believe that dieting is regarded as most useful. 'Varsity men who row, we know, eat quantities of underdone steak. The theoretical justification of a large protein intake might be that the specific dynamic action of protein being high, it intensifies metabolism, and so enables the athlete to make the best use of his food (and aids deposition of muscle proteins). But regular exercise is the main thing. This exercise will, if carefully graduated, enable a man to develope a powerful heart, and so to strengthen his circulatory system that it is able to perform the required work.

There is a close relationship between prowess at games, and development of the heart, and it has been established that a man who has by exercise developed his bodily muscles, has a heart of corresponding size and degree of muscularity. This enables an athlete to do work with less distress than is ordinary; he can, with his powerful heart, attain to the required output without the same need for acceleration of the pulse as is felt by a sedentary person. Moreover, a trained man uses his muscles more economically. His nerves, as well as his muscles have been trained, and he does the same work as a sedentary person with less expenditure of energy, and a smaller necessity for a large output.

Smoking is a habit which men in strict training generally eschew. (But not usually at Guy's!) It is well known that nicotine, after a transient stimulation of the vagal nerve endings, will paralyse these endings, and so remove, or partially remove vagal inhibition. One might, therefore argue that tobacco-smoking is injurious to an athlete in training because it increases his pulse-rate, and so abolishes the low pulse-rate which his training ought to have produced. As Lewis admits, in his book on "*Effort syndrome*," while tobacco does few people much harm, and cannot be cited as a cause of effort syndrome, it certainly aggravates the symptoms. And it is widely admitted that tobacco shortens a man's

"wind," and is therefore bad for an athlete in training.

A feature of exercise well known to most people is the onset of second wind. After a varying period of respiratory and circulatory distress, there comes a time when breathing is easier, the distress vanishes, and the athlete feels as if he could continue the exercise for an indefinite period. It is no uncommon experience to see some unfortunate forward, obviously very much out of wind, ploughing along in the wake of a more energetic scrum; and yet after a while that same forward may seem to wake up and perform prodigies of valour.

The onset of second wind is much more gradual in trained persons, and the initial distress much less marked. This might suggest that it is due to a more economical use of the muscles, which occurs in a practised man. This leads to a lessened production of CO_2, a smaller H ion concentration in the blood, and less respiratory distress. But it is, I think, more complex than this, and due to the interaction of several factors.

Pembrey and Cook have observed that the onset of second wind is coincident with the onset of sweating. Further they have noticed that the pulmonary ventilation and CO_2 content of the alveolar air are higher before the onset of second wind. This latter fact may be reconciled with the view that after a little practice, a man uses his muscles with economy. Whilst at the time when sweating begins, the body temperature may so have risen as to alter the conditions in some way. *Starling* thinks that second wind may be due to an improved coronary circulation, or an outpouring of adrenaline.

There is another view which considers that metabolites produced by exercise may produce dilatation of the vessels in the muscles, and so facilitate the flow of blood through them.

I cannot conclude without a word on the effects of exercise upon the heart. There have been many people, and there still are many people, who believe that severe exercise may damage the heart, and produce a condition of heart strain in normal people. Personally I am inclined to believe that exercise is itself limited by the capacity of the heart for work, and that, since this is the case, one cannot perform enough muscular exercise to damage the heart, simply because the heart will not allow it.

A man running in, say, a half-mile race, may be in perfect condition, and running to his utmost ability. And when another runner passes him in the "straight," he may strain every muscle and make every effort to do a final sprint, but find he is unable to. And yet this straining does him no harm. Our Chairman would, I suppose, call it another of the protective mechanisms of Nature. And besides this, the evidence that athletes are subject to heart-strain, and die early, is very small. There is a tradition that men who row in boat-races are affected in after life, but this assertion is not borne out by statistics, according to Lewis. In fact athletes are as long-lived as anybody, or more so. And it is a curious fact that the horse, whose heart is as much called upon as that of any animal, is very little liable to chronic heart affections. Rather let us assume that those who collapse, and suffer any permanent injury while taking exercise, have suffered lately from some infection, which has damaged their heart. In which case they are pathological subjects and do not concern us.

The phenomena of effort syndrome brings me on to difficult ground. In patients who suffer from this, the symptoms which are seen in athletes after heavy exertion, appear after only very slight exertion indeed. The effort syndrome patient, in fact, bears the same relation to the untrained healthy man, as the latter does to the trained athlete, and there are all gradations between these. Effort syndrome is common among soldiers who have been recruited from sedentary occupations. These patients suffer from no structural defect of the heart, but are distinguished by an exaggerated response to the least exertion. Breathlessness, tachycardia, giddiness, and excessive fatigue are common symptoms. And exercise is often followed by stiffness and malaise. The importance of this affection has been shown by Lewis, who asserts that while the figure for cardio-vascular disease was second among all medical ailments which affected our troops during the war, the majority show no clear sign of structural disease, but are cases of effort syndrome.

In view of the importance of the subject, perhaps the meeting will not accuse me of laziness in leaving it to an expert, and asking Dr. Pembrey to give us some account of this condition, which seems to me neither pathological nor physiological.

Interesting Cases in the Medical Wards

Cases under Dr. Hurst, Dr. Hunt, and Dr. Symonds—

Addison 1. Congenital heart.
3. Enlarged liver.
5. Congenital heart.
6. Paralysis agitans.

Mary 35. ? Pituitary tumour.

Papers by Guy's Men.

Sir W. Arbuthnot Lane, Bart., M.S., F.R.C.S., The Hunterian Lecture on Colectomy. Delivered at a meeting of the Hunterian Society on January 19th, 1921.—*Lancet*, January 29th. p. 207.

The Services as a Career for Medical Men.

(*Continued.*)

Let us start where I started. The House. It is one of those Houses that cannot possibly be spelt without a capital H. I first saw its exterior about fifteen years ago and I am afraid that it has not altered much. I say "afraid" because any alteration would be an improvement. To be quite frank it is about the ugliest building of its kind that I know. I have never been to Germany but I imagine that it is much the same sort of building that a German with a "von" in front of his name might have built in the latter half of the last century. It is of stone with spires and peaks which are irresistibly reminiscent of that part of a wedding cake that you must not eat (partly because the gastric juice would be unequal to the task of digesting it and also because it probably has to do duty at subsequent weddings). Anyhow its external appearance matters little. It is now used as an officers' mess and it is shortly to function as a combined Headquarters Mess and Staff College. The grounds immediately around it were laid out for pleasure purposes and they are as yet unchanged. Inside it is what you would expect. The central Hall (I can't help that capital H) would no doubt be described by a house-agent as "a capacious and lofty chamber, surmounted by a crystal dome, elegantly and luxuriously upholstered in gold, etc." However, I need not waste time in describing it all. It has been suitably refurnished and adapted and it makes quite a good mess.

As I have said, the immediate neighbourhood of the house is occupied with what used to be the gardens. Over on the other side of the Tring road lies the camp. When I was there there had been a case of cerebro-spinal meningitis and I was shown the apparatus they had used for dealing with contacts and carriers. It was simply an ordinary army hut with a pipe running around its walls. This pipe contained steam from a boiler outside, and the steam operated about a dozen high pressure sprays containing Izal by means of side jets off the main pipe. In the murky atmosphere thus produced the men were kept for 20 minutes, with the result that "positives" on entrance became "negatives" on exit. The incidence had been low and clearly proved the efficiency of the preventive measures taken. The "carrier" proportion or percentage was always known and they found that they could predict with very considerable accuracy the case incidence from this percentage.

The barracks are not yet built, but I was shown the site where already the foundations were being laid. It is difficult to picture the final result from seeing a few piles of bricks, a number of turned sods and some hundred yards of light railway, but I should imagine that, when complete, the place will be rather like Tidworth on Salisbury Plain, but probably not quite so big. The large permanent Air Force Hospital is also going to be erected here, and I saw the site of it but no more.

At the present time, and until their new home is built, the patients are housed in a number of ordinary huts (part of the original camp) which have been cunningly arranged to serve their present purpose. Covered corridors, sloped so as to avoid the necessity for steps, have been run up and all the buildings are now connected in this way. But if its exterior is unprepossessing its interior is amazingly well equipped and augurs well for the excellence of the new hospital when it comes. First of all the wards. Well, they are much like other wards. About ten or twelve beds in each, if I remember right, and there are plenty of them. There are, of course, administrative quarters, rooms for the C.O. and Adjutant, and an orderly room, also presumably a Quartermaster's office and stores, but these I did not see. The dispensary was not elaborate but quite adequate. Then there was the "Bug Lab." I am not a great authority on "bugs," but the laboratory seemed to be all that you could want, and their bacteriologist did all the work of the hospital and some, I gathered, for the local practitioners in civil cases of infection liable to endanger the health of airmen. At any rate here was a chance for a man to develop his own speciality, to become an expert and to conduct any researches that presented themselves. It is the policy of this service to encourage specialism and, as far as the exigencies of the service permit, to give every opportunity to their medical officers to develop any "bent" they may possess. Next I visited the operating theatre. You cannot expect anything very grand in a hut, but I think that any surgeon would rather operate in this particular hut than in, say, one of the medical wards at Guy's. I heard something of the sort of surgery that they did. They have the usual "Pat and Sam" cases fairly frequently, and acute abdomens and other acute inflammatory conditions quite often require surgical interference. I should think that orthopædic surgery might be a good line to follow up in the Air Force. They seemed quite prepared to tackle anything that came along. Operations for hernia, appendicitis, acute obstruction, mastoid, compound fracture and many others had been done quite recently. There was a massage department with certain electrical machines concerning which I strove to conceal my ignorance, but I feel sure that the

Sister-in-Charge was on terms of easy familiarity with such mysteries as A.C.C., K.C.C., Galvanism, Faradism and the like. An X-ray room there was of course. In fact everything that you could want for up-to-date clinical work. When the new hospital is finished it ought to be one of the finest modern hospitals in the Kingdom.

After a fairly complete investigation of all the resources of this temporary hospital I was taken across to see the first really permanent building that had been finished—the isolation hospital. About the only criticism that one could offer would be that it was a pity it had been built to suit its windows instead of the windows having been made to suit the hospital. The wards are sufficiently light and airy. Each ward is entirely separate with doors at both ends and each is provided with a sister's room, bath room and the "usual offices." It would probably be an improvement to cover in the connecting pathways at some later date so that orderlies and sisters moving about in inclement weather could do so in comfort. That may come. The isolation block is a complete little town on its own, well planned and well built; dealing with infectious diseases ought to be quite a simple matter at Halton. There were not many patients when I saw the place. They had had, as I have mentioned, a case of cerebro-spinal fever and several carriers, but most of the men I saw in the isolation wards were very mild cases of diphtheria—positive swabs in fact.

It must be remembered that Halton is not merely a medical station. I have emphasised the medical arrangements because it was in these that I was particularly interested and because I thought that readers of the GAZETTE might like to hear about them. I also saw a good deal of the other side of the work that goes on there. It is at Halton that the Air Force recruits are trained in the various trades with which every mechanic has to become familiar. The camp occupies the east side of the road from Wendover, a road that divides the Halton Park estate into two pieces. The west side is occupied with the training accommodation. Here are literally acres of workshops in which classes of all sorts are held. Aeroplane construction, motor mechanics, carpentry and so on are taught in these under perfect conditions. Eventually the workshops will repay the cost of erection and upkeep by turning out finished aeroplanes. At present the training is not sufficiently advanced for the production of the finished article, but in a few years time there ought to be a steady output of machines—the products of the pupil mechanics. My words will not be read by any who are contemplating entering the ranks of any of the services, but it will be clear that the Air Force offers advantages to such which are probably greater than anything that the army or navy can offer. For consider. A recruit gets paid—not much it is true; but still he gets pocket money, board and lodging and a uniform allowance —from the day he enlists. From this time until his training is finished he gets all the advantages and none of the disadvantages (in the form of premiums) of apprenticeship to a skilled trade. When his years of service are over he finds himself with a technical education that should enable him to obtain a first rate and highly paid post. But we are not concerned with that side of the Air Force.

That ends my visit to Halton. I have set down here what I saw, as I have said, in the hope of interesting any who have ever thought that a military career would suit them. What struck me most was the evident desire to develop a medical service on new lines—with new ideas and new traditions in place of the old. The opportunities are unique. Here is an entirely new service hardly as yet recognised as a separate medical service in the sense that the R.A.M.C. is. Moreover, the problems with which they have to deal are, many of them, also unique. The psychology, physiology and pathology of the airman present countless avenues for research. Much has already been done, but much more remains to be done. The authorities are alive to the fact that the best brains of the profession must be attracted if the medical problems of flying are to be fairly dealt with. They realise that the best brains in the past were not attracted by the services and they understand why this was so. The result is that the Air Force Medical Service promises to expand along entirely new lines. It is to be a service for the specialist and the investigator, and not for the man who feels that his intelligence is insufficient to stand the test of private practice. The specialist will be allowed every facility for following up cases that interest him. The researcher will be welcomed and his enthusiasm not be regarded as an impertinence. The surgeon, the physician, the cardiologist, the oculist—they are all wanted. The lesson of the war has been learnt. You will not now find the physician in charge of an eye ward, the orthopædic surgeon at the isolation hospital or the bacteriologist directing the massage department. In short here is a service where ability is not regarded with suspicion, where progress is not considered "prejudicial to good order and military discipline," and where, above all, past experience is to be the basis of future enterprise.

It is entered, not by competitive examination, but by selection. On the satisfactory completion of a probationary period as a "short service" officer, the medical officers of this service may either retire with a substantial gratuity, or be confirmed as permanent officers.

A Case of Obesity treated with Thyroid Extract and Low Diet.

IN view of the uncertainty as regards the causation of obesity the following report may be of general interest.

Miss —, aged 25 years, was admitted to Guy's Hospital in July for increasing obesity and consequent inability to work.

Family history.—Her father and mother, who are first cousins, are rather thin. Three sisters and one brother are normal in size and weight. One brother has been abnormally fat from birth and has been unable to do any work.

Personal history.—She had rheumatic fever when six years old, scarlet fever when seventeen, and was treated for anæmia two years ago. During the first three years of the war she was able to work as a wireless operator, but since then has only been able to do light work on the farm at home. Recently she has had headaches and has noticed that her feet and wrists swell after exertion. She is able to walk about two miles a day. Her weight has been as follows:—9 months, 4 stone; 3 years, 6 stone 6 lbs.; 7 years, 10 stone; 12 years, 16 stone; 25 years, 21 stone 2 lbs.

On admission there were immense collections of subcutaneous fat generally distributed over the body.

Her hair was fair and rather scanty. On the inner aspect of both legs above the ankles the hair was dark and there was slight pigmentation of the skin. Her menstrual periods started at the age of fifteen, but only came on about once in six months. The periods lasted about three days and caused little, if any, general disturbance.

Physical examination did not reveal any signs of disease of any organ, except that a soft systolic bruit could be heard over the heart. The apex beat could not be felt and the limits of cardiac dulness could not be made out.

An X-ray examination showed no abnormality of the skull and no enlargement of the sella turcica.

An ophthalmoscopic examination showed nothing abnormal. There was no limitation of the field of vision. The vision with the right eye was 6/18, and with the left eye 6/60. With glasses this was improved to right eye 6/9, left eye 6/12. Thus the eyes were probably the main cause of her slight headaches.

Her sugar tolerance was not tested as on each occasion the glucose produced immediate vomiting. Her blood sugar, taken after a meal containing carbohydrate, was normal, which is suggestive of increased sugar tolerance.

Dr. Fawcett diagnosed the case as obesity due to a congenital derangement of the glands of internal secretion, probably hypopituitarism.

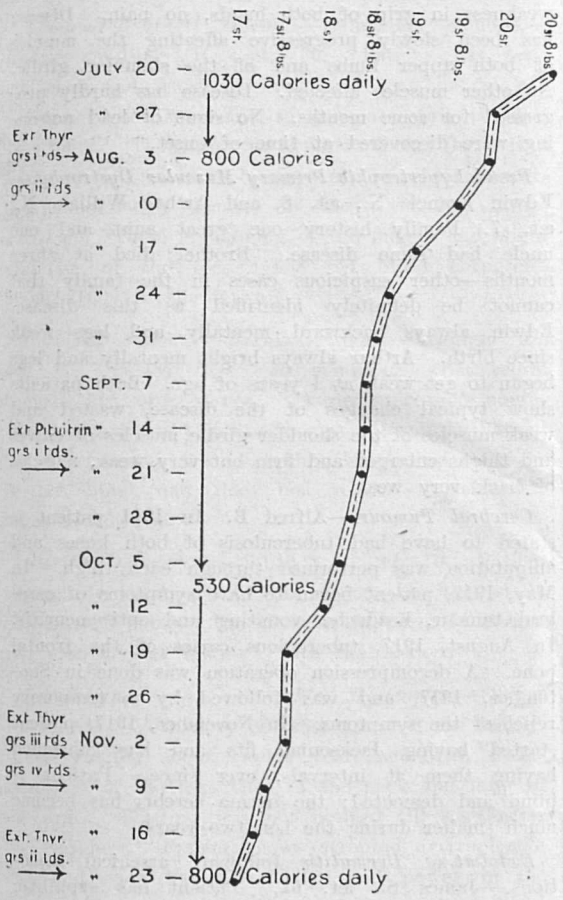
At first, with a view to investigating her normal metabolism on her ordinary diet, she was given bread 1 lb., meat 8 oz., potatoes 8 oz., green vegetables 8 oz., 2 eggs, 2 oz. butter, and fluids *ab lib* (*total calorie value 2,900*), with instructions to eat as much of this as she could. She was only able to eat half that diet and thought that she was then having about her normal diet when she was at home (*i.e.* 1,500 calories). She had not eaten sugar or jam for years, did not like anything containing fat, but was very fond of fruit and vegetables.

While she was on this diet of 1,500 calories daily her metabolism was investigated by Douglas' bag method, the expired air being collected and its CO_2 contents analysed. Waller has shown that this simplified method in which it is not even necessary to determine the oxygen content is accurate to within 5 per cent. which is sufficient for most clinical purposes. Her basal metabolism (resting in bed without breakfast) was represented by an output of 170 c.c. CO_2. Douglas gives the normal for a man of ten stone as 200 c.c. CO_2. Considering her weight this was enormously below the average, but it is difficult to know her true weight of body substance, neglecting the subcutaneous fat which has little or no metabolism of its own. Much more careful experiments would have been necessary to decide whether the metabolism of the body cells was actually reduced or whether the apparent reduction was due to the layer of fat having a low metabolism at the same time preventing the normal heat loss of the body.

An interesting point was that a very approximate calculation of her daily metabolism based on her metabolism at rest, and her metabolism moving about the ward, assuming sixteen hours rest and eight hours of gentle activity, gave a figure of 1,600 calories. This was in strikingly close agreement with the calorie value of the diet which she had chosen for herself and which she thought was the same as her ordinary diet outside. She had found quite empirically for herself a diet which kept her weight about steady between 20 and 21 stone It would have been interesting to see how much her weight would have increased further with a normal diet.

She was then put on the following diet:—bread 4 oz. (calories 360), meat (lean) 4 oz. (calories 300), eggs 2 (calories 150), potatoes 4 oz. (calories 120), green vegetables 4 oz. (calories 25), jam 1 oz. (calories 80), no sugar or butter. Tea and water *ad lib* (a spoonful of milk was allowed with each cup of tea). The total calorie value of this diet was 1,035 calories. A week later the bread was reduced to

two ounces and one egg only was allowed, which reduced the value to just below 800 calories. On this diet she lived quite comfortably from the end of July to September doing light work in the ward and walking in the park. Although she was always ready to do any work that was given her she was extremely slow and deliberate in her movements, and when lying or sitting reading she remained absolutely motionless. Mentally she appeared quite alert and was very keen on reducing her weight and resuming work, but she was slow of speech and seemed of very phlegmatic temperament.



Her change of weight after the special diet was started is shown on the chart. During the first fortnight, on a diet of 1,030 calories, her weight dropped over 10 lbs. The diet was then lowered to 800 calories daily, and at the same time she was given extract of thyroid, three grains daily, and a week later six grains daily.

From the experimental point of view it is unfortunate that both these changes were made at once as it is more difficult to be sure of the causal factor, but from the clinical point of view the result was good, and during the next month under this treatment her weight dropped more than a stone.

During the first three weeks of September she appeared to have reached a new position of equilibrium as regards her weight—at 18½ stone with a diet of only 800 calories daily. She was then given extract of pituitary 1 gr., t.d.s., by mouth. Her weight fell slightly, but as she was still having the thyroid extract and the low diet it is difficult to be certain of the cause.

Her diet was next lowered by one day in three complete starvation, making an average calorie value of only 530 calories daily. Her weight almost at once fell to 17½ stone, and on raising her dose of thyroid extract it fell further to 17 stone. This dose of 10 grs., t.d.s., was not continued for long as her pulse became faster. Before she was discharged her weight appeared to be remaining steady, with a diet of 800 calories, and six grains of thyroid extract daily. She went home with instructions to continue this treatment under medical supervision and I hope to hear that with a more active life which is now possible her weight will continue to fall.

It would be interesting to know how far it is possible to generalise from a pathological obesity like this to the milder degrees of obesity which are so common. Obviously, when obesity is once established a vicious circle develops. There is less spontaneous activity to stimulate metabolism, and the layer of fat diminishes heat loss and so preserves more body substance from Katabolism. But in this case the evidence points to some more fundamental abnormality. In spite of the improvement under thyroid treatment there were no signs of thyroid deficiency, and the two most probable alternatives seem deficiency of pituitary or of ovarian secretion, or perhaps of both. The condition appears to have been congenital and familial. I am much indebted to Dr. Fawcett for permission to publish this case.

J. M. H. CAMPBELL.

THE EDITOR will, at all times, be glad to consider articles or sketches, provided that they are accompanied by the writer's name and address, not necessarily for publication. The payment that the GAZETTE *can offer is merely nominal. Authors who desire reprints of their papers should make their own arrangements with the printers when they return their proofs. All contributions to be addressed to the Editor, "Guy's Hospital Gazette," Guy's Hospital, London, S.E.*

Clinical Demonstration at Lambeth Infirmary.

Arthritis Deformans (probably infective).—William T., æt. 38. Many years ago patient had a urethral discharge. Twenty years ago patient had "trouble" in feet but cannot remember much about it. At the beginning of 1920 patient had multiple acute arthritis and was kept in bed for 8 weeks, diagnosed as acute rheumatism. Patient has a very chronic arthritis of nearly all the joints of the body. There is great thickening of the synovial membranes and some periarticular thickening with limitation of movement. X-rays do not show any important changes in the bones. There are no tophi. The Wassermann reaction is negative.

Ateleiosis and ? Late Rickets.—Percy Ernest B., æt. 24. One of five children all the others being healthy. Patient's father, two aunts and one uncle show similar skeletal abnormalities and a greater or less degree of infantilism. Patient was healthy and apparently normal till 16 years of age, but then he had pain in all the "joints" and stopped growing. Deformities have gradually appeared since then. Patient corresponds with the development of a boy of about 14—very little hair on his face and high-pitched voice—normal intelligence. All the long bones are deformed, the epiphyses being much more affected than the shafts. X-rays taken two years ago show very thick epiphysial cartilages with exaggerated rachitic changes. X-ray at the present time shows the cartilage to have been replaced by bone, but the epiphysial lines can still be distinguished. The genitalia are normal. The Wassermann reaction was negative two years ago.

? Late Rickets and ateleiosis.—Charles B., æt. 49. Father of previous patient. Skeletal changes first made their appearance about puberty, but patient has always been able to do full work until an injury in February, 1920. He is of dwarfed stature, but looks his full age and is of average intelligence. All the long bones are deformed and X-rays show much irregularity about the epiphyses.

Spastic Paraplegia—Rachitis Kyphoscoliosis.—Arthur B., æt. 18.

Spastic Paraplegia—Combined Sclerosis.—John P., æt. 63.

Spastic Paraplegia—Imbecile.—Hilda S., æt. 35.

Disseminated Sclerosis.—Annie M., æt. 37.—Patient dates her illness from 1905, when she had a radical mastoid operation. Since then she has been gradually losing power in her legs. She has constant tremor of the head from side to side and an easily elicited intention tremor of the hands—nystagmus when looking to either side but more marked when looking to the right. The knee jerks are increased, double ankle clonus and double Babinski—*i.e.* she has spastic paraplegia. Patient is unable to walk, is occasionally incontinent of urine, and the mental condition has deteriorated rapidly during the last few years. Sensation normal. Wassermann on C.S.F. and blood serum negative. Speech varies much—at times it is quite characteristic—diplegia at times.

Progressive Muscular Atrophy.—James E., æt. 35, painter by trade. Started 10 years ago with weakness in grip of both hands, no pain. Disease has been slowly progressive affecting the muscles of both upper limbs and of the shoulder girdle. No other muscles affected. Disease has hardly progressed for some months. No signs of lead poisoning were discovered at time of onset.

Pseudohypertrophic Primary Muscular Dystrophy.—Edwin Francis N., æt. 8, and Arthur William N., æt. 7. Family history one great aunt and one uncle had same disease. Brother died at three months—other suspicious cases in the family that cannot be definitely identified as this disease. Edwin always backward mentally and legs weak since birth. Arthur always bright mentally and legs began to get weak at 4 years of age. Both patients show typical changes of the disease, wasted and weak muscles of the shoulder girdle, muscles of calves and thighs enlarged and firm but very weak, muscles of back very weak.

Cerebral Tumour.—Alfred B. In 1911 patient is stated to have had tuberculosis of both knees and amputation was performed through each thigh. In May, 1917, patient began to have symptoms of cerebral tumour, headache, vomiting and optic neuritis. In August, 1917, tuberculous caries of the frontal bone. A decompression operation was done in September, 1917, and was followed by a temporary relief of the symptoms. In November, 1917, patient started having Jacksonian fits and has continued having them at intervals, ever since. Patient is blind and demented; the hernia cerebri has become much smaller during the last two years.

Exfoliating Dermatitis following arsenical injections.—James S., æt. 62. Patient has syphilitic endarteritis obliterans with extensive cerebral thrombosis giving rise to hemiplegia, and organic dementia. From 6th September, 1920, to 11th October, 1920, he had six intravenous injections of arsenic followed by weekly injections of mercury. On 17th January, 1921, the present eruption made its appearance and rapidly spread until he is now nearly covered with rash.

Recurrent Carcinoma Mammæ—Carcinomatosis cutis.—Henrietta H., æt. 49. Left breast was amputated

in May, 1920. During the last six months patient has noticed the small tumours of the skin which are now seen. Scattered over the surface of the scalp, neck, trunk, arms and thighs, are numerous, small, slightly tender nodules of growth; most of them are reddened and one on the scalp has ulcerated. The left supraclavicular and right axillary glands are enlarged and the liver is palpable irregular and tender. Patient says she has lately had "rheumatism" of the right hip and the upper part of the right thigh is tender on deep palpation.

Congenital Heart Disease.—Pulmonary stenosis.—Charles William H., æt. 36. Patient has been cyanosed and short of breath as long as he can remember, but was able to stay at work till last November. The heart is hypertrophied; there is a harsh systolic murmur heard over the whole præcordial area, being loudest at the third left costal cartilage. There is clubbing of the fingers and slight clubbing of the toes. The red blood corpuscles at 9,200,000 to the c.mm.

Cerebral Tumour—Hernia cerebri.—Reginald L., æt. 17. Patient has had symptoms of cerebral tumour just over a year. A decompression operation was performed at St. Thomas's Hospital. Patient has a very large hernia cerebri, left hemiparesis; he is not blind and does not vomit. Considerable organic dementia.

Osteitis Deformans.—William L., æt. 70. Patient shows the changes of the disease in the skull, clavicle and spine. The tibiæ are apparently normal and cast normal shadows with the X-rays.

Pseudohypertrophic Muscular Dystrophy.—George W., æt. 24. No history of other cases in the family. Illness started about twelve years ago with weakness, first of the legs, then of the back and later of the arms. Wasting was not noticed till long after the weakness. Patient shows atrophic dystrophy of legs and back but has fairly good power in the hands. There is a tenderness to contraction of the legs.

Pseudohypertrophic Muscular Dystrophy.—Patrick C., æt. 25. A brother in Dartford Asylum. No other members of the family affected. Illness first noticed after an attack of pneumonia seven years ago and has been slowly progressive since. Legs are atrophied and weak; hands are weak but shoulder girdle not markedly affected. There is no history of enlargement of the calves so that he has probably been atrophic from the first.

Mitral Stenosis—Polycythæmia Rubra.—Edward George J., æt. 38. Quite healthy until 3 years ago when his illness started with shortness of breath and pain in chest and was diagnosed as empysema and bronchitis. Since middle of January his breathing has been very distressed and he has become cyanosed. Patient has severe chronic cyanosis. Heart is enlarged and there is a loud presystolic bruit all over the præcordial area, loudest at the impulse. His red blood count is:—Hb. = 140 per cent.; total red = 6,000,000 per c.mm. = 120 per cent.; C.T. = 140/120 = 1·1.

Spastic Paraplegia—Tubercle of spine.—James Bernard A., æt. 20. Upper dorsal.

Spastic Paraplegia—Syphilitic pachymeningitis.—Augustus M., æt. 43. Has been under treatment for syphilis for three years.

Case of Melanotic Sarcomatosis.

J. McC., boiler maker, æt. 61 years, admitted into Stephen on the 24th December, 1920, for pain in right side and enlargement of the abdomen.

P.D.I.—In July, 1915, a piece of metal entered the right eye and after treatment it was found in February, 1916, that a "cancerous tumour" had formed, so the eye was enucleated.

H.P.D.—Quite well and working until September, 1920, when he began to have pain in the back and over the right hip. In October he began to become constipated. The pain increased in intensity. Two weeks before admission his abdomen began to feel hard and painful. No diarrhœa. He noticed a lump in the left forearm a short time ago. Appetite good. A week before admission his doctor found that he was becoming yellow and that his urine was a dark brown. For six months he has had difficulty in commencing micturition, and he has been losing weight.

C.O.A.—Patient definitely jaundiced, and slightly drowsy. The right eye socket appears healthy.

Right Arm.—There is a hard irregular lump about half an inch long in the triceps muscle. A lipoma two inches by three fills up the ante-cubital space.

Left Forearm.—There is a similar lump to that in the right triceps.

Alimentary System.—Oral sepsis, tonsils enlarged, containing much pus.

Abdomen.—Much enlarged, girth at umbilicus 37 inches. Subcostal angle very wide, and there is a mass which pushes the xiphisternum forwards. Liver greatly enlarged, reaching to within an inch of right anterior superior iliac spine and one inch below the umbilicus. The left lobe is two inches below the left subcostal margin. Outline and surface regular, except for prominence mentioned. The liver dulness reaches to the 4th rib. No ascites. Bowels constipated, fæces slightly pale.

Rectal Examination.—Prostate smooth and slightly enlarged.

Cardio-vascular System.—Slight thickening of radials.

Respiratory and Lymphatic Systems normal.

Left Eye normal. Nothing detected in central nervous system.

Urine.—Deep brown, sp. gr. 1030. One specimen showed darkening on standing. Albumen, pus, blood, and bile not detected. Gives the nitro-prusside test for melanogen.

Fæces.—Reaction neutral, no meat fibres, but some fat globules seen. No blood present.

On the 4th January, 1921, patient died.

Autopsy, No. 7 of 1921, by Dr. Mutch.—There were a number of purplish black spots shining through the skin over the right shoulder. (These were not present on admission.) A number of small hæmorrhagic spots were seen on the pericardium and around the trachea which, on section, proved to be deposits of melanin. One small nodule on the surface of the left lung. Spleen twice the normal size. The liver weighed 7,000 grammes and was infiltrated with secondary deposit, so that it was difficult to find any normal tissue. There was no obstruction of the bile ducts. The lumps in the right triceps and left forearm were secondary deposits, the former pigmented, the latter showing no naked-eye pigmentation. Small mass on ileum two feet from ileo-cæcal valve. Kidneys slightly granular, with a few white nodules in each. Brain normal, no extension through orbit.

The sections, seen by courtesy of Dr. Nicholson, showed that the liver was diffusely infiltrated by an alveolar, small-celled melanotic growth, the pigment occurring in patches and being present in the cells as well as in the connective tissue. The cells have a great resemblance to those seen in the skin, and are obviously epithelial in type and manner of growth, and have practically replaced the liver tissue.

The tumour in the ileum was an encapsulated, basal-cell carcinoma attempting to form alveoli, and similar in type to those sometimes found in the appendix.

Three small nodules in the kidneys were cut. The first was a small suprarenal rest. The second was a tubular adenoma of the kidney showing calcification in a few places. The third was a papillary adenoma.

The other secondary deposits showed the same characteristics as those in the liver.

The interesting feature in this case was the length of time, over four and a half years, elapsing between the origin of the primary focus and the appearance of metastases. Cases in which an even longer period has elapsed are on record, so that it appears unwise to regard the case as cured even after an interval of years. Although the exact nature of the injury was not known, it is interesting to speculate upon the possibility of a tear in the choroid, resulting in an implantation of the pigmented cells in the retina.

In conclusion, I wish to thank Dr. Fawcett and Dr. Mutch for permission to publish this case.

E. F. W.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

A Case from Clinical.

DEAR SIR,—In your current issue M. M. states that the Case from Clinical, under the care of Dr. Fawcett, showed an absence of ankle jerks and also of ankle clonus. As ankle clonus is an impossibility in a limb which has lost the ankle jerk, it would appear that the significance of the Achilles tendon reflex, and possibly of other reflexes, has been missed by the author. Similar errors appear with some frequency in medical publications and detract considerably from the reader's opinion of the clinical acumen of the writers.—I am, Yours very truly,

HILDRED CARLILL.

146, Harley Street, W. 1.
January 25th, 1920.

Our contributor, M. M., writes in reply:—

[Although in essence the above criticism is sound, it really does not require an authority like Dr. Carlill to realise that if the calf muscles fail to contract on tendon tapping they will also fail to yield a clonus on dorsiflexing that foot. So much was obvious even to an elementary student of medicine (like myself).

But though it is permissible for experienced physicians to omit essential points in an examination, it is necessary for the ordinary person to set down in a report each single physical sign as it is elicited —however dull and redundant these facts may appear to be: *it is part of the routine.*

Had the writer realised that his communication was to be examined with that higher criticism that one associates with a Driver or a Luzatto, he would have been more careful.—M. M.]

The War Memorial.

SIR,—Will you allow Amy Levy's verses to plead for the Guy's trees?—

"Green is the plane-tree in the square,
The other trees are brown;
They droop and pine for country air,
The plane-tree loves the town.

Here from my garret pane I mark
The plane-tree bud and blow,
Shed her recuperative bark,
And spread her shade below.

Among her branches, in and out,
The city breezes play;
The dull fog wraps her round about;
Above, the smoke curls grey.

Others the country take for choice,
And hold the town in scorn;
But she has listen'd to the voice
Of city breezes borne."

Yours, etc.,—

A DWELLER AT THE GATES.

27th January, 1921.

G.P.s and House Officers.

DEAR MR. EDITOR,—I enclose herewith a copy of a letter which I, as a House Officer, recently received from a doctor in general practice in the country—

From ———, G.P.

To House Officer, Guy's Hospital.

Re —— ——, aged 13 years.

Dear Sir,—I am very much obliged to you for your report on my patient.

If you ever have (?) the misfortune to go into G.P. you will find that you send some of the most interesting of cases into hospital and only receive a report about them in some 10 per cent. Your firm is one of the exceptions.—Yours truly,

—— ——, G.P.

Such a letter as this must surely act as a stimulus to all men holding House Appointments to send to all G.P.'s, over whose cases they may have had temporary charge, the fullest particulars about all investigations or operations performed in hospital.

The more frequently we do this, the less frequently, I am confident, will we receive interesting cases from G.P.'s accompanied only by a visiting card on which is written the temperature, pulse, and possible diagnosis.—Yours truly, HOUSE OFFICER.

Dental Society.

THE usual monthly meeting of the Dental Society was held in the Club Smoking Room, on Tuesday, 18th January, at 5 p.m., with Mr. E. C. Hughes, a Vice-President of the Society, in the chair.

The minutes of the previous meeting were read and confirmed and after a brief discussion it was decided to hold a Cinderella Dance under the auspices of the Society, probably some time in March.

Mr. G. Tonkin then read an interesting paper on "Oral Sepsis," in which he pointed out the evident relationship which exists between oral sepsis and the course and termination of a large variety of general diseases, particularly gastric, rheumatic, arthritic, and many others which appear in a large majority of cases to be aggravated by a septic condition of the gums and alveolar bone, such as occurs in pyorrhœa alveolaris. This subject gives wide scope for discussion and controversy, and quite an interesting discussion followed, in which the chairman and various members took part, several interesting cases being quoted in support of the contention that the removal of the oral sepsis so often means an immediate improvement in the general condition. Mr. Hughes was asked to give the surgical aspects of the matter as compared with the evidence on the dental side given by the others present.

There was, on this occasion, a slight improvement in the number present, though the meeting still only represented about 15 per cent. of the total number of dental students, so that at a low estimate about 70 per cent. of dental students take no interest whatsoever in meetings which concern their future and afford an opportunity of broadening their views and better preparing them for their life-work.

In this connection one might add that it is to be regretted that no medical students found their way to this particular meeting as the matter discussed concerned them vitally, and might have served to stimulate discussion.

The next meeting will be held on 15th February.

Presentation to Mr. F. J. Pearce.

AN interesting little function took place in the Dental Conservation Room, at 1 o'clock on Wednesday, 19th January, when a silver tea-set, suitably

inscribed, and a case of fruit-knives were presented by the House officers and students of the Dental Department to Mr. Frank J. Pearce, L.D.S.Eng., D.D.S.Penn., Assistant Dental Surgeon at the Hospital, the occasion being the latter's marriage.

The presentation was made in a few well chosen words by Mr. G. K. Moore, a senior student, who voiced the sentiments of all who were present, and in fact of all the students, among whom Mr. Pearce is considered one of the most popular members of the staff, not only for his readiness in helping those who need assistance or advice and his sterling qualities as a teacher, but also because of his personal qualities, his courtesy and friendliness towards one and all. Even the most junior student feels when talking to Mr. Pearce that he is conversing not so much with an august member of the staff, but rather with a friend and a good fellow who meets one on an equal footing. Mr. Pearce, who appeared much overcome, expressed his sincere thanks and appreciation and alluded to the spirit which pervades Guy's, perhaps more than other similar institutions, and which made such a gift all the more valuable in his eyes, a gift which he hoped to hand down in his family as an heirloom.

Reviews.

A Guide to Anatomy. For Students of Medical Gymnastics, Massage, and Medical Electricity. By E. D. Ewart. (H. K. Lewis & Co., Ltd.). Price 16s. net.

This book distinctly marks a forward step on the road towards the ideal text-book of Anatomy for training students in Medical Gymnastics. But we feel that there is not sufficient detail in it to cover the syllabus and to satisfy the examiners of the Chartered Society.

For instance, the origins and insertions of muscles are given too vaguely (the accurate ligaments of the diaphragm are not even mentioned, and the crura are said to arise from "lumbar vertebræ.") Again, the formation and position of the lumbar plexus are dismissed in four lines of small print. In some places the text is so elementary as to be almost misleading, *e.g.*, "the auricles are two soft, ear-shaped structures, which lie closely against the base of the heart at each side." (p. 127).

Several printers errors require correction in any further edition such as on p. 267 "Abductor" Magnus, and on p. 84 "Diarihosis."

The diagrams are clear and well chosen. They should prove of great value, being less complicated than those in the larger text-books and therefore easier to understand and to reproduce in examination papers.

If it is borne in mind that the Author does not intend the book to be considered a "complete guide" (*vide* Preface) it will no doubt prove a useful work.

Lectures to Nurses in Training. By Miss M. Vivian, A.R.R.C.. (The London Scientific Press, Limited.)

It is a well known saying that we must learn by experience; its truth is demonstrated every day, and with greatest profit when our experience recalls long forgotten teaching. This little book of nursing ethics explains hospital customs, points out the path in which a probationer should tread, and advises her with insight and sympathy throughout the stages of her hospital career. The young nurse who reads this book may have a few years to wait before she appreciates the full wisdom of its teaching, but she cannot fail to be immediately helped by it, in her daily tasks.

Surgical Nursing, and the Principles of Surgery for Nurses. By Russell Howard, C.B.E., M.S., F.R.C.S. (Messrs. Edwin Arnold.)

This book is already well known, and the fourth edition, in which the work has been entirely revised and brought up to date, will be welcome in the nursing profession. Students who wish to have a concise handbook of nursing details in surgery, will find this book useful.

A Pocket-Book of Ophthalmology. By A. J. Ballantyne, M.D., F.R.F.P.S.Glasgow., (Messrs. E. and S. Livingstone, Edinburgh, 1920.) Price 5s. 6d.

This synopsis of ophthalmology is provided with blank pages upon which the student is invited to draw diagrams and insert supplementary notes culled from his lectures or his wider reading. In the hands of a diligent student with a penchant for the construction of diagrams this pocket-book might be transformed into quite a useful volume. As it stands at present, it can only recommend itself to those men that have a thorough working knowledge of ophthalmology and need a book of moderate proportions for pre-examination revision.

The Theory and Practice of Nursing. By Miss Gullan, Sister Tutor of St. Thomas' Hospital. (Messrs. H. K. Lewis & Co., Ltd.)

In this work the author has achieved a notable success. She takes a wide aspect of the ground which a nurse's knowledge should cover; and in her preword suggests that each chapter shall act as a framework into which "future Sister Tutors may weave their own pictured patterns." Miss Gullan

rightly believes that the probationer should learn to understand and use the scientific terms commonly employed in clinical teaching by the staff, and, having explained these terms, she uses them throughout her chapters. If one may venture to suggest an addition to so valuable a book, a chapter on bed making, bed sores, pediculi, and some good methods of overcoming daily nursing difficulties, might well come within the scope of the title, and the chapters on micturition and catheterization might widen to include the nursing of genito-urinary disease, a subject too often neglected by teachers.

Surgical Nursing and Technique. By Mr. Childe. (Messrs. Ballière, Tindall & Cox.) Third edition.

This is a clear, well thought out book, designed by its author for nurses, dressers, house surgeons, etc. The first chapter deals with the characteristics of the ideal surgical nurse, and Mr. Childe rightly sets a very high standard, and at the same time draws attention to the need for reform in the length of a nurse's hours of work. After a chapter on Asepsis, Antisepsis, and lessons learnt during the late war, the author traces the history of a surgical patient, from the moment he enters a hospital, or home until his discharge. No practical detail, from the nurse's or house surgeon's point of view, is omitted, and the chapter dealing with the full preparation of the operating room, its contents, and inmates is excellent. There are some good plates, and diagrams of instruments and appliances.

Football.

Items of Interest. Rugby Football.

On Saturday, January 29th, Major S. McK. Saunders revisited Honor Oak Park and saw the match against Catford Bridge. Major Saunders played as a forward for many years, leading up to the season 1907—1908. He was Captain of the Rugby XV. (1906—1907) season. Fast, and with wonderful command of the ball, he was a very valuable forward. He attained County Honours for both Devon and Kent. For many years he has been serving in the East.

Hearty congratulations to W. D. Doherty on becoming Captain of the Ireland International XV. To be, in one season, Captain of Ireland, Captain of Surrey, Captain of the United Hospitals and of Guy's, is indeed a record.

May one also congratulate the Bart.'s Captain on being Capped for Wales. All will agree that M. G. Thomas richly deserves the honour the Welsh Selection Committee has done him.

GUY'S v. CAMBRIDGE UNIVERSITY.

This return fixture was played at Cambridge on Wednesday, January 19th, and strange as well as sad to relate, the Hospital were beaten by exactly as many points as at Honor Oak Park when the same teams met in November. There was no doubt but that on the day Cambridge were the better side. They were much more fit than our men and it is evident that the Hospital will have to seriously train to get themselves into condition again. Christmas has not been conducive to keeping our men in hard football fettle.

There were 14 Blues against us on January 19th. The only non-blue being the full back, H. F. Cockill (Emmanuel), it will be remembered that Cockill filled this position last term giving way in the 'Varsity match to Watson who got his Blue in 1919. We faced the stiff wind the first half and no doubt the energetic tactics of our forwards put, for a time anyhow, the 'Varsity off their game, and after only a few minutes play Steyn opened the scoring for us with an unconverted try. Our line almost fell just after, but some hefty footwork we got play to midfield again. From here, however, the Cambridge backs got the ball and D. Cook registered a try. The pace against the wind was telling against the Guy's pack and as half-time approached Miller, of Cambridge, got Morel, their fast forward going. Poor half-hearted tackling let Morel right through the backs to gain a try for Conway to convert.

On changing ends the Hospital men failed to benefit by the following wind. The early portion of the game had taken too much out of them. Twice more Cambridge scored. Craigmile and D. Cook getting further tries and Conway kicking one more goal. Steyn got one try and Van Schalkwijk converted, while bad luck, in the shape of the corner flag, robbed us of what appeared another legitimate try. These corner flag tries are always unsatisfactory and as in this case no try was awarded the final score read:—Cambridge University, 2 goals 2 tries, 16 points; Guy's Hospital, 1 goal 1 try, 8 points.

Guy's Team.—H. Van Heerden, H. K. Williams, C. L. Steyn, P. K. Albertijn, A. Daneel, F. Bekker, J. G. Van Schalkwijk, W. D. Doherty, F. W. Reitz, E. E. Neser, A. H. Shelswell, H. Van Zyl, H. J. Taylor, F. J. Biddle, L. K. Watson.

GUY'S HOSPITAL v. H.A.C.

Though the best and heartiest of triers, it must be stated at once, that the "Company," as the gallant men at Finsbury are called, did not extend us very much on Saturday, January 22nd, 1921.

The scoring began almost as soon as we got on the field the ball reaching Steyn who very quickly put on a couple of tries, one of which Reitz converted with a particularly good kick. Sprong, working at the scrum base behind a victorious pack who were heeling smartly, got the ball away, though he should curb his anxiety and not pick out of the scrum; it is a bit dangerous. Good passing sent Van Heerden over with our third try. Then Steyn dropped a good goal. All this time Daneel had made many attempts to score on the left, but each time he was hampered by the touch line, the ground being rather narrow as space is limited at the Armoury House ground. Before half-time Albertijn gained a try and Van Schalkwijk kicked a goal. Then Neser and Shelswell added themselves to the list of scorers. Neser's try was the consummation of much passing from Sprong and about six others, all the way from midfield to goalline. Sprong was very good indeed, though one would like to see him play in the Hospital colors, possibly he was asked to play rather too late to make arrangements.

As soon as we resumed the H.A.C. gave a great spurt and only some timely saving by Olivier kept our line intact. Soon the forwards, all of whom played well, dominated the game again, the ball being flung about by forwards and backs, though the referee seemed to think that a goodly number of the passes were forward, that did not prevent Van Heerden and Van Schalkwijk crossing for unconverted tries. Albertijn secured three more. He played excellently and his intuition and backing up was most valuable. Duncan and Shelswell put on a couple and Van Schalkwijk converted two of the tries leaving Neser to be successful with a wide shot from the try which Shelswell secured. Daneel put in a very excellent afternoon's work. He was, as stated, hampered by the touch line; his other trouble was getting in front of Albertijn. The Final score read: Guy's 6 goals (1 dropped) and 8 tries to nil. Total, 53 points to nil.

The H.A.C. proved themselves hospitable and friendly enemies and one wished almost that they could have been more successful. Many were engaged, till comparatively recent times, in a much more deadly game and it is a matter of time to again perfect the old peace time relaxations. One, at least, of our opponents had secured the greatest Military Honour His Majesty can bestow.

Guy's Team.—W. Olivier, H. Van Heerden, P. K. Albertijn, C. L. Steyn, A. Daneel, E. L. Sprong, J. G. Van Schalkwijk, F. W. Reitz, E. E. Neser, R. F. H. Duncan, A. H. Shelswell, L. K. Watson, F. J. Biddle, W. H. Taylor, R. R. Macintosh.

GUY'S v. CATFORD BRIDGE.

Time was when Catford used to run us to a very close margin, but since the War they have not been able to command the old standard of player, nor to replace those numerous gallant Catford men who were killed. On Saturday, January 29th, they were but poorly represented, and Guy's had honestly very little to beat. It provided the Hospital with plenty of running and passing practice, but not much else. What we lack most is thorough tackling. Even on Saturday men were going shoulder, neck, and even head high. Is this why Cambridge beat us twice? Guy's tackling is not at the moment at concert pitch. Some men, mind you, are jolly good; let the others go low, go thoroughly, and make sure of their men.

Steyn had quite a field day on Saturday; he ran in with 6 tries and had a hand in several others. Albertijn was the scorer of 4 tries; he also had a hand in most of the attacks. Sprong got a couple; he played much better than the previous Saturday, getting the ball away well, and also varying the game neatly. Daneel got 3 tries; he is a much faster player than last year, and goes for the line with refreshing vigour. One may say that all the three-quarters are much more hearty in attack than early in the season. There is more determination in the running. J. A. Krige was not very fit, and the pace was such a cracker there is little wonder he soon felt the strain. Krige was credited with a try; he deserved it for his good run, but he really lost the ball before he touched it down. Shelswell and Van Schalkwijk were also try getters. Neser kicked 1 goal, Van Schalkwijk 6, and that is all; 7 goals 11 tries—68 points to nil. Neser played one of his best games; so did Duncan. It seemed to be a pity not to let Neser take all the distant place kicks and practise with them; surely a good opportunity. Three place kicks that failed hit the cross-bar or uprights.

Guy's Team.—W. Olivier, C. L. Steyn, J. A. Krige, P. K. Albertijn, A. Daneel, E. L. Sprong, J. G. Van Schalkwijk, F. W. Reitz, A. H. Shelswell, C. Marais, E. E. Neser, A. H. Van Zyl, R. F. H. Duncan, W H. Taylor, R. R. Macintosh.

Association Football.

GUY'S v. H.A.C.

Played at Honor Oak Park on Saturday, January 15th. The Hospital played a strong side and a very fast game resulted, although the pitch was very greasy owing to the recent rains.

The outstanding feature of the game was the wonderful goalkeeping displayed on both sides, the H.A.C. goalkeeper in particular bringing off some most daring and brilliant saves. The H.A.C. scored at the end of about 12 minutes. From the re-start the Hospital equalised after some fine passing among the forwards, Trott scoring. Play was very fast, both goals continually being in danger. After the H.A.C. had scored, the Hospital equalised through Williams.

Contrary to expectations the pace did not slacken in the second half. The H.A.C. scored early, but Williams headed in a corner by Morgan. Van Geuns was injured and had to retire. The H.A.C. scored again, leaving the final score 3—4 against us.

Guy's Team.—E. Hardy, T. M. Fripp, A. W. Riddolls, O. T. Painter, D. J. P. O'Meara, D. H. Couch, R. Van Geuns, W. Nicholls, L. S. Williams, L. A. S. Trott, and V. R. Morgan.

The forwards played very well indeed, being well controlled and fed by Williams. Wing to wing passing might be a little more indulged in. The full backs showed great lack of understanding and were not too sure in the tackling.

GUY'S "A" v. OLD CHOLMELIANS "A."

Played at Honor Oak Park, on Saturday, January 8th; this was the first match of the second half of the season, and despite the ground, which was very slippery and heavy, a keen and interesting game resulted in a 1—0 victory. Guy's started two men short, but pressed more vigorously now than at any other period of the game. About half-way through the first half Crisp scored. After this play became much more even but the defence held out well and no further score resulted.

Guy's Team.—Mackeith, Wakeford, Robertson, Trafford, Painter, Hewitson, Jones, Crisp, Williams, Nicolai, Hardy.

GUY'S "A" v. H.A.C. "A."

Played on the H.A.C. ground, on January 15th, in a thick fog which made accurate play impossible. As far as could be made out a very even game resulted, which H.A.C. won by the only goal of the match scored from about the half-way line.

Guy's Team.—Silver, Wakeford, Robertson, Rayner, Palfry, Trafford, Jones, Graham, Crisp, Nicolai, Hewitson.

GUY'S "A" v. BORO' COLLEGE "A."

Played away on the 22nd. Guy's had much the best of the first half and soon became one up through Gonsalves. Guy's still did most of the pressing, until Wayman was injured; however, the Guy's defence held out with the help—on one occasion—of the referee, and there was no further scoring.

Guy's Team.—Silver, Rayner, Riddolls, Palfry, Trafford, Hewitson, Robinson, Graham, Crisp, Gonsalves, Wayman.

Other Results.—Guy's "A" 1, Royal Dental 2.

LONDON UNIVERSITY ASSOCIATION CHALLENGE CUP.

The draw for the Third Round of this Cup was made at University College, on Wednesday, January 19th, 1921, and resulted as follows:—

A. Guy's Hospital v. Birkbeck College.

B. St. Mary's v. London School of Economics.

C. East London College v. London Day Training College.

D. Regent's Park v. King's College.

To be played on the ground of first drawn club on or before Wednesday, February 9th.

Semi Final.

Winners of C. v. Winners of D.

Winners of A. v. Winners of B.

To be played on neutral ground.

Hockey.

GUY'S HOSPITAL v. R.N.C. (GREENWICH).

Guy's were at home to the R.N.C. at Forest Hill, on Saturday, 29th January, and a very fast and capital game resulted in a win for the Hospital by 7 goals to 3.

Several changes were made in the Guy's team, K. Hooper filling the centre-half position, A. L. McKay taking the left-half and J. R. A. Moore the right-half positions, whilst R. Schofield took the responsible position of Goalkeeper, vice. C. T. V. Baugh, who was unable to play owing to injury.

Play was very even for the first quarter of an hour, some lively exchanges taking place. Kennedy opened the scoring for the College by a very clever shot. The Hospital forwards retaliated and by good combination made repeated attacks on the visitor's goal, the College custodian effecting some brilliant saves. B. M. Tonkin, who was at his best, netted three times in quick succession for the Hospital, and Kennedy added another point for the College. Half-time was reached with the score 3—2 in our favour.

In the second half the Hospital forwards combined with much dash, and further goals were scored by J. W. Schollum (3) and F. E. Graham-Bonnalie (1). Just before time was sounded the College scored again, and a very enjoyable game ended in a win for the Hospital by 7 goals to 3.

The Hospital forwards played with much better combination, though many opportunities were missed in the circle. The half-backs were good, though, I feel sure, a little more precision in passing would be greatly welcomed by the forwards, and would

render the attack more dangerous. Our backs, particularly W. F. Hurdle, were very sound, and R. Schofield, though not called upon very frequently, made one or two fearless saves.

Guy's Team.—R. Schofield, W. F. Hurdle, C. G. Bowen, J. R. A. Moore, K. Hooper, A. L. McKay, W. S. Hunt, J. W. Schollum, B. M. Tonkin (Capt.), F. E. Graham-Bonnalie, and L. E. Owen.

Inter-Hospital Cross-Country Cup.

The race for the Kent-Hughes Cup has been fixed for Wednesday, March 2nd, from the "Green Man," Blackheath. This course will be an easy one of seven miles, and there is no limit to the number of entries from each hospital, although only the first five from each will count. As far as we know this Cup has not been held by Guy's since the eighties, but it will certainly come back to us again this year if men, who know they can run, or think they can run or even who are willing to try to run, will get as fit as they can by March 2nd. A few enthusiasts catch the 2.22 p.m. from London Bridge (S.E. & C.R.) to Lewisham Junction every Wednesday, and run five miles from the "Green Man," but just lately they have been well outnumbered by the Middlesex contingent, the greater part of whose rugger fifteen has now taken up cross-country running. The runs are followed by hot baths and tea, and nobody has yet been down who has not felt better for the afternoon. But better or worse, we must have that Cup.

Guy's Hospital Golfing Society.

A meeting of the Golf Committee was held on 21st January, and it was decided to stimulate interest among the golfing members of the Clubs' Union by holding a Handicap Knock-Out Competition to be played off as soon as a sufficient number of players have put their names on the list in the Colonnade.

All men who are members of the Clubs' Union are allowed to enter for this competition, also for the monthly Medal Competition held on the first Wednesday of each month. The Medal round is either a stroke competition or against Bogey, the winner receiving a silver spoon.

During the ensuing season matches will be arranged with other London Clubs and Hospitals also. The Inter-Hospital Cup, at present in the hands of Guy's, has to be played for. Dr. Cameron, the President, has kindly presented two boxes of balls to be competed for during the season.

F. W. CROOK, Hon. Sec.

Change of Address.

B. Burnside, Argent Street, Katanning, Western Australia.

C. G. Coombs, M.R.C.S., L.R.C.P., The Mental Hospital, Pietermaritzburg, Natal, South Africa. (Permanent.)

E. Lawrence Davies, Undercliffe, Dawlish, Devon.

E. S. Phillips, Fairfield, Hayes, Middlesex. (Permanent.)

Dr. W. K. McKay, Assistant Medical Officer, Anglo-Persian Oil Co., Maidan-i-Naphthun, Persia, via. Bombay.

Arthur F. Hurst, New Lodge Clinic, Windsor Forest, Telephone: Whitefield Row 25.

Lancelot Bromley, M.Ch., F.R.C.S., 17, Harley Street, W.1.

M. C. Joynt, Nqamakwe, Transkei, C.P. South Africa.

Geoffrey Marshall, M.D., M.R.C.P., to 31, Wimpole Street, W.1. Telephone, Park 4316.

N. S. Carruthers, F.R.C.S., to Kenmare Brundall, and 48, Prince of Wales Road, Norwich. Telephone, Norwich 1439.

R. J. Hearn, M.A., M.D., B.C. Telephone, Mayfair 6550.

We regret that we wrongly announced Mr. Howell's change of address in our last issue to 7, Imperial Square, Cheltenham, where he has been for the last 20 years. We also apologise for having described him as O.B.E. instead of C.B.E.

Birth.

BURNSIDE.—On February 22, 1920, at Perth, West Australia, the wife of B. Burnside, M.R.C.S., L.R.C.P., of a daughter.

Marriage.

PEARCE—VERDEN.—On January 20th, at Pinner, Frank James Pearce, of 57A, Wimpole Street, to Phyllis Crome, daughter of Mr. and Mrs. Mark Verden, of Pinner.

ED.—M. E. S.

GUY'S HOSPITAL GAZETTE.

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Passim.

WE wish to draw the attention of Fellows of the Royal College of Physicians to a radical alteration which has recently been made in the Bye-laws of the College relating to the nomination of fit and proper persons for the Fellowship. In the past, Members of the College could be nominated for the Fellowship both by the Councillors and by other Fellows of the College.

Councillors of the College can no longer nominate such persons, and hence the duty devolves in future solely upon those Fellows who are *not* Members of the Council. It is essential that this change should be recognised in order that the Council, when they come to consider the list of Members recommended for the Fellowship of the College, should have before them a thoroughly representative list from which to select.

The regulation now reads as follows:—

"Any Fellow of the College, *other than Councillors*, may propose for the consideration of the Council for nomination to the Fellowship any Member of the College who has distinguished himself in the Practice of Medicine, or on the pursuit of Medical or General Science, or Literature."

The grounds of the recommendation must be fully stated in writing, for the information of the Council, and forwarded to the Registrar not later than the *First* day of March.

WE have been asked to draw the attention of our readers to the fact that in future Clubs' Union membership cards must *always* be produced in order to secure free admission to the Ground at Honor Oak Park for football matches. Since these cards were introduced this rule has been somewhat loosely interpreted, but we are assured that it will be enforced with the utmost rigour on all future occasions, and that anyone who claims free admission without producing his card, however distinguished he may be, will be made to pay the usual admission fee. Ladies are no longer admitted free, and tickets for the Stand do *not* include admission to the Ground.

THE War Memorial volume of the Guy's Hospital Reports, the final volume of the old series, is now nearing completion. As it is hoped that the record of war services that it is to contain will be as complete as possible, proofs of this record will be posted in the Colonnade, Students' Club, and Medical School as they come to hand from the printers. All concerned are

asked to scrutinise them and to notify any errors to the Medical School Office.

The Inaugural Meeting of the University of London Union Society was a complete success. The Great Hall at King's College was full to overflowing, and the first motion, "That a University of London Union Society be, and is hereby, formed," was carried with enthusiasm and complete unanimity. The most troublesome discussion of the meeting raged round the difficult question of eligibility for membership. Everyone appeared agreed upon the principles, but it was not found easy to frame a sentence which should include all the right people and exclude all the wrong ones. At any rate all medical students are to be included amongst those eligible, no matter whether they be actually members of the University, in the stricter sense of the word, or not.

There still seems to be much distrust of the Union at Guy's, and probably also at the other Hospitals. Although we think that the Union provides a great opportunity for Hospital men to gain something which their University life has hitherto been unable to offer them, it must not for a minute be thought that the success of the Union depends in any way upon the attitude of the Hospitals. The Hospitals are only quite a small part of the University. The success of the Union is assured whether the Hospitals come in or not. If they do not, it is the Hospitals and not the Union which will, in the long run, be the losers. If the Hospitals wish to remain active institutions in a great University, if they wish their point of view to be spread abroad amongst their fellow students of other Colleges, if, in short, they wish to break down the isolation of their past existence and to become a real influence in the University of which they are by no means insignificant Colleges, then, by having a large and powerful section of their members on the Union they will be going the right way to achieve their object. If their wish is for none of these things, then they will be failing in their obvious responsibilities as members of the University. The Hospitals have never been lacking in esprit de corps. Surely the wider patriotism demanded by a University will not fail to appeal to those who have always so finely upheld the narrower traditions of College patriotism !

On Tuesday last a University of London Boat Club was inaugurated at a meeting held at University College. We understand that the University has in contemplation the purchase of a riverside site at Chiswick and that eventually the headquarters of the newly-formed Boat Club will be situated there. In the meantime it is hoped that College rowing may be stimulated by the existence of a University organisation, and with this end in view some Inter-College races have been arranged, and these will be rowed off in May. It was further suggested that at some time, inevitably rather remote at present, a London University crew might participate in the Annual Inter-varsity contest from Putney to Mortlake. High ideals are an excellent stimulus to good work, and such a prospect ought to rouse enthusiasm in the hearts of all oarsmen at the University of London. Although London has an excellent stretch of river, better in many ways than either Oxford or Cambridge, the parts available for rowing are too far distant to make it an easy matter for crews to get constant practice. However, such difficulties are not insuperable, and it will rest largely with the keenness of individual men and Colleges to make the U.L.B.C. a success.

The position of the United Hospitals Rowing Club will not be materially affected by the

new University Club. The Inter-Hospital race is the only function for which the former club is responsible, and there will, of course, be sufficient cohesion between these two clubs to ensure that fixtures do not clash. The possibility of University Rowing with further enable a start to be made at Hospitals and Colleges which have so far had too few rowing men to provide a nucleus for a College crew. We wish every success to this new venture, and we hope that the Guy's Boat Club, the holders of the Inter-Hospital Cup, will not be behind in demonstrating their aquatic prowess to the other Colleges of the University of London.

In a letter to the *Times* which appeared on Tuesday last, Sir William Hale-White suggested that a suitable memorial to Keats would be the endowment of a Ward. This is an admirable suggestion, and we hope it will not pass unnoticed by those who, while admiring Keats, have money to spare for charitable purposes. But whether a "Keats Memorial Ward" materialises or not, we hope that the Keats Centenary will not be allowed to pass without some recognition by the Hospital of the fact that Keats was a Guy's man. This no time for spending large sums from funds already severely overtaxed, but surely we might have some small tablet or memorial brass placed in some conspicuous place to remind future (and present) Guy's men that Keats was of their number. To many here at present the fact is probably unknown. To those who come in future years the fact will remain undiscovered until the bicentenary again focusses public attention upon it. The names of most of our illustrious men are commemorated within our walls. Surely Keats is worthy to be counted of their number.

An Editor always feels satisfied if his remarks provoke correspondence on the part of his readers. Some satisfaction is ours, therefore, in having stimulated comment on our remarks about the trees in the Park. Let us at once assert that our original opinion is unchanged, although it has been misinterpreted by our correspondents. We should be the last to suggest that *all* the trees, or even that the *majority*, should be cut down. But when some fifty odd trees of various sizes and shapes occupy so small a space as the unbuilt-on Hospital grounds, we feel there is room for some thinning (with two n's, please, Mr. Printer!) without damage, and, indeed, with improvement to the health and appearance of the Hospital. We shall be pleased to demonstrate the disadvantages of certain of the trees to "Resident" during the course of the summer. To X.Y.Z. we would reply that a re-perusal of our remarks will show him that he has not understood them aright.

The Musical Society's Concert was distinguished by two outstanding features. Firstly, the perfect singing of Mr. Clive Carey, and, secondly, the ridiculous paucity of men in the choir. Is it really true that out of 700 odd students only three have sufficient enthusiasm to assist the Musical Society? If this is really so, we doubt whether the Society will ever give a Choral Concert again, for it is obviously absurd to have to rely on such a small number. To us it is amazing that it should be so, but it seems a common experience with many other Hospital Societies. There is no keenness, no enthusiasm. What has happened to the Debating Society? We cannot remember a single meeting during the winter session. An effort was made last term to re-start the Glee Club. About eight men turned up on the first occasion, took away some music, and never came again. And yet when a University Union is suggested, one hears it said that we have sufficient activities of our own. Can our readers explain?

Another Guy's man has received International Honours in Rugby Football. This is Mr. Graham-Davies, who has been "capped" for Wales against France next Saturday at Cardiff. We offer him hearty congratulations.

The Concert.

IT was a very great pleasure to be able to welcome Mr. Clive Carey at the Musical Society's concert on Tuesday, the 8th. Without in the least detracting from the admirable work of the Chorus and soloists we may be allowed to say that Mr. Carey's solos lifted the concert above the average of concerts, and the whole concert was above the average; the programme was most attractive and showed that much thought had been expended on its composition and arrangement.

Knowing what great difficulty is encountered by the conductor in collecting the members of his chorus for practices, all praise must be given him and his chorus for the excellent result; perhaps the sea songs of Vaughan-Williams, with Mr. Carey as soloist were the most finished; the piano effects were excellent. Hubert Parry's "Jerusalem" was very pleasing. The male portion of the Choir, through illness, was sadly attenuated, Mr. Shaw, indeed, had to sustain the tenor part unaided; this he did with unflagging energy. The basses were without the help of the other Secretary, Mr. Gallagher, but were strong enough to hold their own against the soprani and contralti.

Mr. Carey sings always delightfully; he treated us to several nautical ditties and some folk songs, one of which was an old favourite in a slightly new guise, "Come now tell me true, my boy Billy". One great charm of Mr. Carey's songs is that every word is perfectly clear, also he gets character into his songs. Several encores were demanded and acceded to, but the audience would have liked to be unkind and listen to many more. Mr. Carey has our very hearty thanks for giving us such a number of delightful songs and sparing so much time; we understand he had to drag himself away from a rehearsal of a play and return to it again after the concert. In addition to choral items, there were quartets from the "Mikado," and very charming they were, Gilbert and Sullivan opera always is a pleasure to listen to.

Nurse Dalbiac also sang some solos; she has a very true and clear soprano; if we may be permitted to say so she does not chose songs worthy of her voice. The accompanying was absolutely first class, and a piano duet, for four hands, was played by the accompanist, Mr. Angus Morrison, and Mr. Bradford, who was also the composer. There were elements of considerable humour in the composition and we shall look forward to hearing it again and other compositions from Mr. Bradford.

This was the first public concert given by the Society since the war and its excellence testifies to the energy of the Secretaries and Conductor, not to mention the Sisters and Nurses and men who have to devote precious hours to practising. Let us hope that next year the supply of men will be greater; among the large numbers of students there must be many who would enjoy choral singing.

Let us add that the comfort of the audience was catered for by the scarlet cushions on the wooden seats of the Physiological Theatre.

Programme.

1. Part Songs—(1) "Haymakers, Rakers," (Charles Wood); (2) "Since thou, O fondest" (Hubert Parry); (3) "Rolling down from Rio." (Edward German)—The Choir.

2. Solo—Nurse Dalbiac.

3. Songs of the Fleet, by Henry Newbolt, for Baritone Solo and Chorus (C. V. Stanford)—(1) "Sailing at Dawn"; (2) "The Song of the Sou'-Wester"; (3) "The Middle Watch"; (4) "The Little Admiral"; (5) "Farewell"—Soloist, Mr. Clive Carey.

4. Piano Duet—"Divertimento for 5 instruments" (H. St. J. Bradford, arranged by Angus Morrison), (1) Rondo; (2) Andante; (3) March—Messrs. Angus Morrison and H. St. J. Bradford.

5. Two Quartets—(1) "Strange Adventure" (from "The Yeomen of the Guard"); (2) "Brightly dawns our Wedding Day" (from "The Mikado") (Arthur Sullivan)—Nurses Dalbiac and Cornwall, Messrs. Shaw and Houghton.

6. Solo—Mr. Clive Carey.

7. Two Madrigals—(1) "The Silver Swan" (Orlando Gibbons, A.D. 1612); (2) "April is in my Mistress' Face" (Thomas Morley, A.D. 1594)—The Choir.

8. Three Nursery Rhymes—(1) and (2) "Lullaby" and "Willie Winkie" (H. Walford Davis); (3) "The White Paternoster" (H. Walford Davis)—The Choir.

9. Solo—Mr. Clive Carey.

10. Two Quartets—(1) "In Silent Night" (J. Brahms); (2) "Love, Fare Thee Well" (J. Brahms)—Nurses Dalbiac and Cornwall, Messrs. Shaw and Houghton.

11. "Jerusalem" (Hubert Parry)—The Choir.

Change of Address.

Dr. Fawsett, 50, Heneage Road, Grimsby.

Dr. T. Reuell Atkinson, 50, Marina, St. Leonards-on-Sea.

E. R. Stone, M.B., B.Ch., B.A., Central Malay Asylum, Tanjong, Rambutan, Federated Malay States.

Recurrent Dreams.*

. . . I could be bounded in a nutshell and count myself a king of infinite space, were it not that I have bad dreams.—HAMLET, ACT II., SCENE 2.

IT may be, perhaps, that an apology is needed as foreword to so intangible a topic, or that the reader, scanning these lines and lighting upon the name of Professor Freud, will venture no further, fearing revelations of Cimmerian turpitude. Let him be reassured. For I can offer nothing that would bring a blush to the most maiden cheek. The dreams I propose to consider are not inspired by Venus, the dreamers are not fashionable neurotics, but men broken in spirit by the sterner god of war.

Those of us who have to do with the neuroses as seen in shell-shocked soldiers have perforce to deal much with dreams. These products of psychic activity, till recently discarded as a medley as meaningless as the flight of ideas seen in acute mania, have through the light thrown upon them by the schools of Vienna and Zurich acquired signal significance. We now possess a technique for their interpretation which in skilled hands is capable of revealing much of the hidden conflict that underlies the neurosis, the elucidation of which is an essential for its cure.

To those who have reflected upon the subject of the war dream, a feeling cannot, I think, be avoided that in some of them at least we are faced with a rather different problem to those encountered in the dreams of our civilian patients. And in this respect, that in certain dreams, and they are generally of the recurrent type, one encounters a resistance different in *quality* to that which we are accustomed to meet when approaching complex material in the ordinary way.

From the start the patient can tell one nothing—or perhaps he tells, as it seems, everything, and yet one feels no nearer to the solution of the problem than before. Space does not allow me to enter at all fully into the many interesting technical peculiarities presented by these recurrent war dreams, let us however consider as briefly as may be the laws which Freud lays down as governing the choice of dream material.

The dream source is almost invariably taken from events of the day preceding—"The dream day." "I am of the opinion," he says, "that the stimulus for every dream is to be found among those experiences 'upon which one has not yet slept' for a night."* And again "what has occupied our minds during the day also dominates our dream thoughts, and we take pains to dream only of such matters as have given us food for thought during the day."

Here at the outset in the recurring dreams we would seem to have a marked dissimilarity. Freud classifies dream sources into four categories:—

1. A recent and psychologically significant experience which is directly represented in the dream. The more or less undisguised battle dream might be included in this category, save in point of view of recency.

2. Several recent, significant experiences, which are united by the dream into a whole.

3. One or more recent and significant experiences which are represented in the dream by the mention of a contemporary but indifferent experience.

4. A subjective, significant experience (a recollection, train of thought) which is regularly represented in the dream by the mention of a recent but indifferent impression.

None of these groups appear to fit the recurrent dream. For the feature of the recurrent dream as I have encountered it consists in a continued linking up of the dream with a definite traumatic experience or experiences, either as a direct reproduction or in a symbolised form, which is liable to persist, though with lessened affective intensity after the original source of trauma has been elucidated.

Freud, himself, mentions one instance only of a perennial dream, in a young physician of his acquaintance, who frequently in his dreams saw a certain yellow lion, a childhood recollection of a cherished toy. The memory of this lion was, however, simply utilized in the dream work, and played apparently many rôles, an entirely different proposition to that we are now considering, in which the entire dream structure recurs unchanged.

Let me quote a case—the first, incidentally—which gave me a clue to what I consider to be the true nature of dreams of this class.

A youth of 24, a poor type, almost a high grade defective, was transferred to my care during the holiday of a colleague. He was intensely frightened, and at first very reticent, but when a satisfactory *rapport* had been established told me of a dream, which he said had been constantly troubling him since he fell sick some three years previously. It was, as far as I could gather from his disjointed account, an almost photographic reproduction of an actual incident, in which he had bayoneted a German who attacked him whilst sheltering in a shell hole. The incident itself I succeeded in reviving, after a

*This paper, with minor modifications, formed an address read before the Psycho-Neurological Society.

*Traumdeutung, pp. 141, *et seq.*

struggle in which both of us were reduced to a state of exhaustion. There was a highly satisfactory abreaction and I felt convinced that *that* affair at least had been adequately dealt with. At the next visit I inquired the dream history, to be told that the same dream had recurred several times. "Ah," I said, confident in the curative value of my abreaction, "but it didn't bother you much this time, did it?" "Oh yes, sir," he said almost eagerly "it seemed worse than ever." It appeared therefore as though there were still some affect attached to the incident, and I proceeded to induce him to recount the experience again. To my surprise the resistance and subsequent abreaction were as great as ever.

To cut the story short, the following week, the same performance was repeated—a severe effort to break down resistance, and a violent reaction afterwards. At this stage the patient returned to his own physician. I was, however, able to ascertain that he showed no signs of improvement, and that this same story had been revived with a similar effect before ever he came to me. The case was subsequently transferred to a Neurological Hospital, as being unsuitable for out-patient treatment, so that I lost sight of him.

This case, although its conclusion remained "wropt in mystery," gave me furiously to think. For it looked as if one's cherished theories of abreaction were, in some cases at least, entirely without validity. But from analytical experience I knew that a memory, frequently repeated during the associations, which may perhaps have been at some time charged with considerable affect, but that could now be mentioned by the patient with indifference, generally served the resistance as a cover memory for deeper matters. Indeed had it not been for the intense abreaction I should have classed the dream merely as a phase of resistance and have approached the buried material by some other avenue. As it was I had perforce to class the incident as one of those unexplained happenings which so frequently beset us in our explorations of the psyche.

My next case was a typical anxiety neurosis in a man of 29; an intelligent type, suffering little from a pension complex and eager for recovery. After several sittings in which nothing of particular interest was elicited, he brought up to me the following dream:—

—"I seem to be behind a wall, there are shells bursting behind us, and there is someone calling out orders from a window up above me."

Associations on the dream recalled a fairly exact picture of the wall, but the memory could not be linked up with any definite incident. At subsequent sittings he constantly reported the recurrence of the dream, so much so that our usual greeting used to be "Well, where are you now?" "Oh, I'm still behind that d—— wall, sir." The persistence of the dream began to play on his mind, and he made vigorous efforts to link it up with actuality, writing to his comrades, re-reading his old home letters, etc.; on one occasion he drew a detailed picture of the wall, all without success. At last I put him under hypnosis, and then suggested that he was again behind the wall; after a few seconds he jumped up, shouted "Oh! my shoulder," and awoke, rubbing his left shoulder. Questioning elicited little; it seemed, he said, as though something had fallen on his shoulder, but what he did not know. He had no recollection of dreaming he was behind the wall, and my suggestion that it might have been the wall which had fallen met with no response. Next time he proclaimed himself immensely better, the dream had not returned, and he felt a weight off his mind. A pain, however, which he had previously complained of in his right temple had now shifted to his left. From that time on he never looked back, and on discharge save for slight occasional pain in the temple, appeared completely well. We never progressed to any further enlightenment as to the locality of the wall.

Here again the abreaction theory seemed at fault. The incident, whatever it may have been, was never brought into consciousness, there was no emotional discharge, in the proper sense of the word, and yet the dream disappeared leaving behind it an obviously hysterical pain in the left temple. Moreover the man got well, and for the last five months has remained so.

Fortunately about this time I read in Dr. Hurst's Croonian Lectures of two cases treated at Seale Hayne for hysterical deaf mutism by strong suggestion under light etherization. Both men, up till the time of recovery had had a perfect recollection of all that they had gone through, writing letters of description, etc. Immediately their speech and hearing returned they developed a complete amnesia, one for all events later than his departure from New Zealand, the other for everything subsequent to his being blown up. Whether the amnesia was or was not recovered the account did not state. Here, obviously, the psychic and somatic elements of the conversion hysteria were readily interchangeable. The amnesia that followed recovery, was as much a hysterical symptom as the deaf mutism had been. Indeed that such interchanges between psychic and somatic *do* take place is apparent to anyone who has seen at the Special Neurological Boards, cases cured of some conversion hysteria by gross suggestion, presenting all the symptoms of anxiety hysteria, symptoms which had appeared for the first time after the removal of the somatic lesion.

That the dream can behave in other respects in an identically similar fashion to the waking anxiety

state we know full well. Thus Freud treating of anxiety dreams says, "If we subject the content of the dream to analysis, we become aware that the dream fear is no more justified by the dream content than the fear in a phobia is justified by the idea upon which a phobia depends. . . . The same explanation, then, which applies to the phobia applies also to the dream of anxiety."* It would seem possible, then, to suppose that the recurrent dream is a psychic symptom utilizing the same mechanisms that are operative in a conversion hysteria,—*i.e.* that having found in the symptom a suitable outlet for disagreeable affects, the patient displaces on to it all the anxiety from which he suffers. The element of auto-suggestion, moreover, enters very largely into the perpetuation. The dream has occurred with much discharge of anxiety, the patient fears a repetition, the repetition occurs, and the idea of recurrence becomes rapidly established, till soon he fears to go to sleep for fear of its recurrence. The dream path becomes a well worn track, and every step on that *via dolorosa* is familiar with monotonous certainty. He may, indeed, say to himself that it is only a dream, but still the well-remembered horror is repeated, till as before he awakes with all the manifestations of acute terror. Like the hysterical deaf mutism, it is the hysterical continuance of a concept which had at the moment of its production a definite and logical psychic cause.

Let us consider two further cases in the light of this interpretation.

Case 1.—S. H. W., æt. 44. A tough, seasoned old soldier, complaining much of sleeplessness, nightmares, and impairment of memory. Did not talk much of war, but when he did laughed about it. He complained of two frequently recurring dreams. The first related to a definite incident in which he and a German grappled in No Man's Land, the German grasping him by the throat and endeavouring to drown him in the mud. Eventually as he was at his last gasp, the German became alarmed and made off towards his own lines.

At the outset of treatment the point at which the patient awoke was always that at which the German was drowning him. He was made to talk over the affair, but there was little or no reaction, he fully realized the horror of the situation, but although it could be vividly recalled there was no perceptible distress. An explanation was then given much on the lines that one would use in treating, say, a case of aphonia.

Next week the dream recurred, but missed out the crucial incident; he simply found himself lying in the mud, and the German was walking back to his lines. He awoke laughing. After this there was no repetition.

*Traumdeutung, Ch. IV.

The second dream proved more obdurate. As he lay in bed he heard footsteps mounting the stairs, someone went into his son's room, there was a blow and the thud of a body falling on the floor. For some sittings nothing could be elicited, but at our eighth interview he recalled a singularly unpleasant experience when a number of Germans were murdered in cold blood. The thud he associated with the falling of an officer with a rifle butt.

For three weeks the dream disappeared, but recurred, coincident with a time of domestic anxiety. The inhibitions had, however, become so far removed, that he was able on hearing the footsteps to say to himself "*Its only a dream,*" he felt impelled, nevertheless, to leap out of bed and go to his son's room to reassure himself that the lad was safe.

Since then on one or two occasions the dreams cross his mind in sleep, but the anxiety has vanished.

Case 2.—H. F., a soldier, æt. 46. An obvious martial misfit, a small, unambitious clerk, employed in a subordinate position with the same firm for 16 years. After a short time at the front, he was blown up and buried, and for some hours lay practically covered with *débris,* and in great terror lest he should be forgotten.

Two dreams, both relating to this incident occurred regularly, and had done so for over two years, accompanied by much painful emotion. They are worth quoting *in extenso,* as showing how an elaborate symbolism, such as these dreams exhibit, may become stereotyped by repetition.

November 12th, 1920.—In my dream I dreamed that in the dark I came to a kind of structure, and as I looked into it I saw that the only light in it came from above. I looked up and saw a man at work. My first thought was to reach him. There was no other means but by climbing through different floors which could be seen through, they being of a kind of lattice work interwoven, after the pattern of bed lathes. In some way or other I reached the first obstacle in my endeavour to get to the top, but as I grasped the lathes they began to bend, so much so that in my frightened state I thought they would snap and I should drop. Each floor I climbed through seemed more difficult the lathes bending more as I got nearer the top. I had come to the last floor and was almost to the top when the lathes bent to the point of breaking, at that moment I woke up feeling bad.

November 19th, 1920.—I found myself in a vault and as I groped about in the darkness, I found that my only way out was up a kind of shute, but to my amazement I could not ascend it, for a massive stone barred the way. Persons above were trying to rescue me and several attempts were made with chains and ropes fastened round the stone, but

every time the stone got hauled up about half-way the chains and ropes broke and down came the stone again. In my terrified state, thinking I must remain there and die, I saw around me many skeletons of persons who had met a similar fate to that which faced me. At the point of giving up hope of being rescued I awoke.

Free association yielded nothing further than the revival of the incident, indeed it would seem as though the manifest content had undergone a sort of degeneration, almost akin to the stereotyped mannerisms of dementia præcox, so that the symbolism had long since lost any meaning it may have had for the dreamer, and had become rigid in character. There was some revival of the original affect, though not in any way a striking reaction. After this sitting the dreams recurred on several occasions over the space of a fortnight, accompanied by unpleasant emotion. The explanation of their perpetuation was several times repeated, and now they have ceased at night—the case is still under treatment—although they now cross his mind occasionally, as waking hallucinations, especially in the dark. They have, however, lost their terror.

A noteworthy point in both these cases is, I think, the gradual manner of their disappearance, coincident with the gaining of insight as to their nature on the part of the dreamer. Here again the parallelism between the recurrent dream and the conversion hysteria is fairly close.

Moreover the return of the dream in case 1, marking a period of regression is familiar to us in other fields. Thus a young woman suffering from an anxiety hysteria whom I saw recently, had at the onset of her malady which had been provoked by the infidelity of her husband, developed an hysterical torticollis. This had been cured by electrical suggestion. "But," she said "if ever I'm worried about my hubby I find my neck twisting round again." As in the dream, each regression was marked by a recurrence of the initial symptom.

Freud has, I understand, a study of dreams of violence (*sträfetraume*) in preparation in which he postulates the existence of an older psychic mechanism at work beneath the Pleasure-Pain principle, which is affected by sudden traumata, which reach it too suddenly to be assimilated by the Pleasure Pain principle. The memory of such events tends to recur spontaneously in dreams until such an absorption has taken place. Without having read the pamphlet it is impossible to offer any criticism of this theory.

It may seem, perhaps, that the question of whether or no certain dreams may be hysterically perpetuated is not a particularly vital one. But as I have tried to show, the acceptance of this theory would cut clean across the generally received views of the significance of dream activity. I have not time now to enter into the vexed question of the sexual elements underlying the war neurosis, beyond saying that in my opinion there is every reason to believe that a certain proportion *do* definitely exist in which the sexual element enters not at all. Whether or no sexual activities underlay any of the dreams I have cited I do not profess to know. A psychoanalyst interpreted the wall dream as a birth phantasy, and the climbing dream of Case 2 is certainly suggestive.

On the therapeutic side, too, the cessation of these dreams marks a very distinct forward step. As the patient progresses the dreams become modified and it is sometimes valuable to suggest that a change in their character will occur as a result of treatment.

One patient was much troubled by a dream in which he fled from a man grotesquely attired as an old shepherd. The pursuit led him across country, over hedges and ditches, till at the moment when his pursuer was about to catch him he awoke. I suggested that the next time the dream occurred he would stand still and ask the man his business. He did so, and the grotesque shepherd tore off his wig and beard, to reveal the features of the dreamer himself. After that the dream ceased.

Furthermore, as was seen in case 1, the dreamer when once insight has been gained, is able himself to overcome the inhibitions the dream previously produced.

G. H. F. G.

Interesting Cases in the Medical Wards

Cases under Dr. Hurst, Dr. Hunt and Dr. Symonds—

Addison	5.	Congenital heart.
	12.	Lymphosarcoma.
	13.	Rheumatic endocarditis.
	20.	Congenital heart.
	21.	Œsophageal obstruction.
Mary	23.	Infantile scurvy.
	34.	Cerebral tumour.
	35.	Cerebral tumour.
	37.	Exophthalmic goitre.

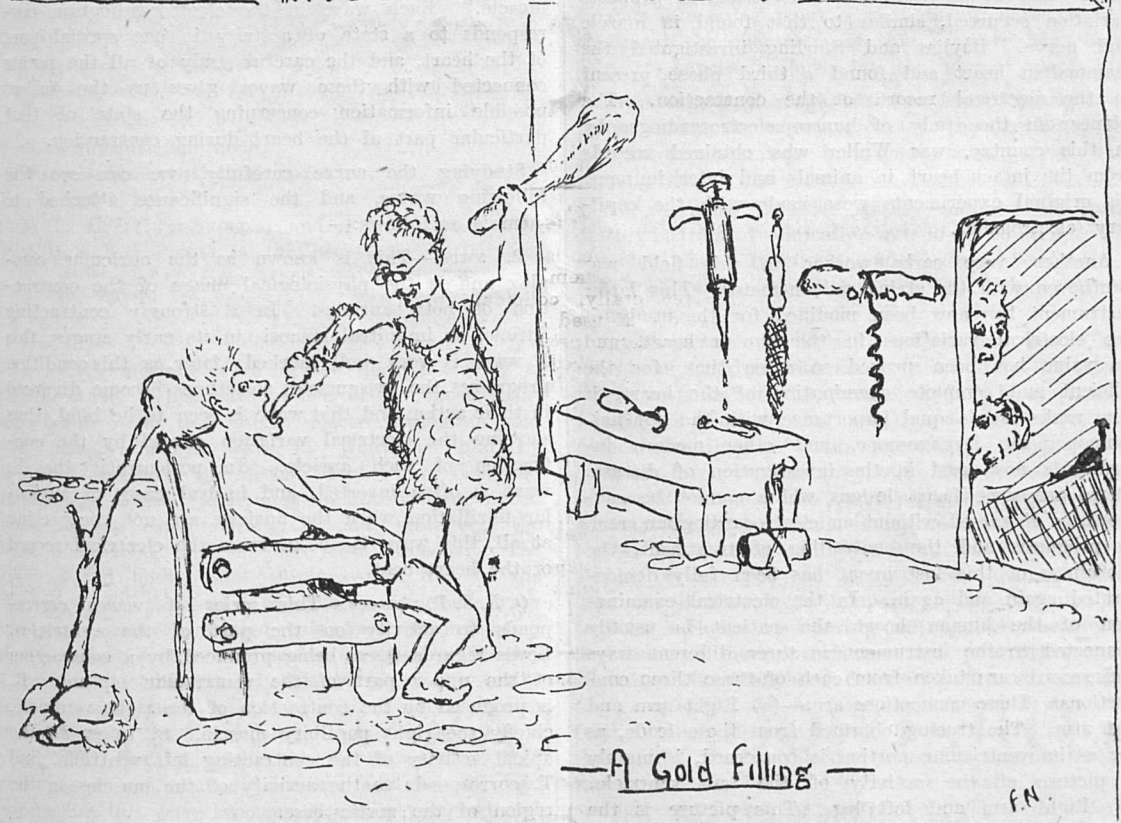
Pass List.

Royal College of Physicians.

The following gentlemen were successful in the recent examination for the Membership.

J. M. H. Campbell. W. E. Robinson.

—Waiting Room—



—A Gold Filling—

PREHISTORIC DENTISTRY.

The Uses of the Electrocardiograph.

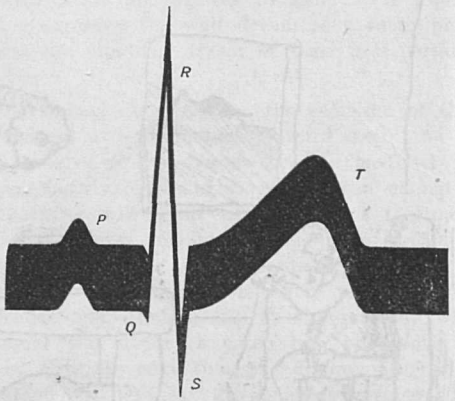
BY W. H. GRACE, M.B., M.R.C.P., D.P.H. (LOND.)

THE activity of most of the tissues of the body is accompanied by a variation in their electrical potential, and this variation can be measured and can be taken as an index of the physiological state of the tissue. This electrical variation is thought to follow closely, and to be an exact representation of, the series of chemical changes which are the direct cause of this state of electrical activity. Some of the tissues can be isolated and their electrical effects studied apart from the body. The heart cannot be so isolated in man and its electrical variations are studied by connecting man to the galvanometer. The man is placed in such a position as will rest most of his skeletal muscles and the heart, being bathed in the body fluids, is in electrical continuity with his extremities which are attached to the galvanometer.

The electrical changes in the heart were first investigated by Burdon, Sanderson and Page (1880), and later by Gotch. These observers used isolated hearts and found that, on contraction, a diphasic variation occurred, similar to that found in muscle and nerve. Bayliss and Starling investigated the mammalian heart and found a third phase present in the electrical record of the contraction. The pioneer in the study of human electrocardiography in this country, was Waller who obtained records from the intact heart in animals and later in man: his original experiments were made with the capillary electrometer.

Another very early worker in this field was Einthoven with the string galvanometer. This latter instrument has now been modified for the study of the electrical variations in the human heart, and its value has been proved so often that, for the efficient and complete examination of the heart, it now ranks as of equal importance with the ophthalmoscope, the laryngoscope, and other modern instruments now used in the investigation of disease. There are some heart lesions which cannot be successfully diagnosed without an electrocardiogram, and, in prognosis and the controlling of treatment, the usefulness of this instrument has been fully demonstrated again and again. In the electrical examination of the human heart, the patient is usually connected to the instrument in three different ways and records are taken from each of these three connections. These connections are:—(a) Right arm and left arm. The tracing obtained from these leads, as far as its ventricular portion is concerned, is mainly a picture of the activity of the left ventricle. (b) Right arm and left leg. This picture is the best indication of the activity of the heart as a whole. (c) Left arm and left leg. The tracing from these leads gives in its ventricular portion, a picture mainly of the activity of the right ventricle.

We can now study the appearance of an electrocardiogram obtained from a normal heart (Fig. 1).



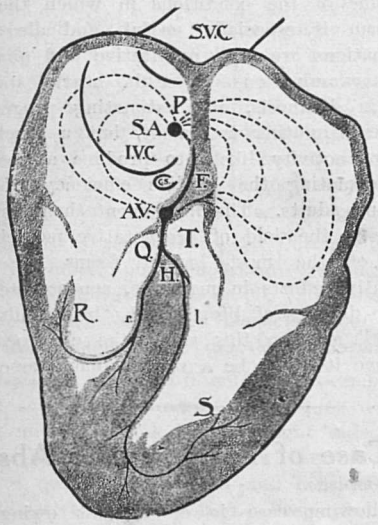
This is a graphic record of the electrical aspect of the beat of the heart, and in the words of an eminent authority, it is "an actual and accurate graphic record of the functional state of the heart muscle." Each wave in the electrocardiogram corresponds to a state of activity in one special part of the heart, and the careful study of all the points connected with these waves gives us the fullest possible information concerning the state of that particular part of the heart during contraction.

Studying the curve carefully, we can see the following waves, and the significance attached to them is as follows:—

P. wave.—This is known as the auricular complex and is the physiological image of the contraction of both auricles. In a strongly contracting auricle, as in mitral stenosis in its early stages, this P. wave is very well marked: later, as this condition progresses, the two auricles sometimes become divorced in their action and this wave is seen to be bifid, thus showing the electrical variation caused by the contraction of each auricle. In pericarditis the P. wave is often inverted, and in bad cases of auricular fibrillation when the auricles are not contracting at all, this wave is absent from the electrical record of the heart beat.

Q. R. S. T. waves.—This series of waves corresponds to activity on the part of the ventricles. Lewis regards Q. as being produced by a contraction of the upper part of the ventricular septum. R. is produced by the contraction of the right ventricle, chiefly the right papillary muscle. S. refers to the apical activity of the contracting left ventricle, and T. corresponds to the activity of the muscles in the region of the aortic base.

The interval P. R. is of maximum importance, as it is an expression of the conductivity of the Bundle of His and is a reliable guide to the condition of this wonderful and important structure. The accompanying diagram (Fig. 2), constructed by Strickland Goodall and Dale Richards, indicates the main connections of the Bundle of His, the all-important path which conducts the stimulus to contraction all over the heart.



By permission of the Editor of "The Practitioner."

S. A. = Sinoauricular node.
A. V. = Auriculoventricular node.
F. = Flack's band.
S. V. C., I. V. C. = Superior and inferior venæ cavæ.
P. Q. R. S. T. = Points in the heart, the activity of which causes the various waves—so named—in the curve.

A very important wave in the normal tracing is the T. wave. This wave is one of the most striking features of the human electrocardiogram and was named the T. wave by Einthoven and by Waller was called the Second Ventricular Complex. It is the largest and most definitely pronounced wave in the electrocardiogram and, strangely, the least understood, and the one most discussed. The view, stated above, that this wave is due to the contraction of the aortic base, is Sherrington's view but most observers regard this wave as indicating the activity of the ventricular base as a whole; a remarkable property of this wave is the striking way in which it varies with different states of activity of the heart muscle. In the heart of a young and healthy adult, the T. wave is a most pronounced and marked feature and as old age approaches this wave becomes gradually flattened and inconspicuous, its amplitude can diminish by quite 50 per cent., and its duration commonly diminishes by 30 per cent. Another striking change in this T. wave is seen in the study of the electrical records of young and healthy hearts undergoing exercise; in this condition, the whole rate of the heart is quickened and its diastolic period is shortened, and the most pronounced electrical response is a marked increase in the amplitude of the T. wave. Therefore, we may conclude that the T. wave can be taken as a measure of the amount of physiological work the heart can do; in this respect it is of enormous value in assessing hearts, especially young hearts and the study of this wave gives us information of enormous clinical prognostic importance: it tell us if the heart is physiologically capable of doing extra work and whether the myocardium which would be called upon to do this work is physiologically and anatomically sound. In prognosis in the many pathological states of the heart, the T. wave is of great importance, and in controlling the treatment of cardiac conditions with digitalis this wave is a valuable guide. A pathological condition which is becoming more clearly recognised daily is a syphilitic myocarditis, and, in severe cases of this infection of the myocardium the form of the T. wave is considerably altered. A further interesting point is that during antisyphilitic treatment the characters of this T. wave have been seen to approach slowly to the normal state.

The electrocardiograph has been conspicuously useful in timing the various events in the cardiac cycle, and in demonstrating how these time periods can vary in health and disease.

We will now consider shortly some of the uses of this instrument clinically, and, in so doing we will consider these functions under three headings:—(a) Diagnosis. (b) Prognosis. (c) Estimation of Treatment.

(a) *Diagnosis.*—In actually establishing the diagnosis, the electrocardiogram is most useful in cases where a lesion of the Bundle of His is suspected. Lesions of this Bundle are due to a number of causes and, in some cases, an accurate diagnosis is essential for a reliable prognosis. Bundle lesions can be roughly divided into two classes:—1. The general conductivity of the Bundle is depressed but no pathological local lesion can be found; the common examples of this type are (a) any acute toxæmia, and here the depression is temporary; (b) Chronic infections such as rheumatism or syphilis where the depression is both permanent and progressive. 2. In this class is included cases of depressed conductivity referable to a local lesion; these can be further subdivided according to the exact spot in the course of the auriculoventricular Bundle where the block has occurred. These are usually auricular, auriculo-ventricular, or ventricular. The electrocar-

diogram can isolate exactly the position of any of these blocks and this information is of special value in prognosis. Another fairly common state in which the tracing is of value is in the differential diagnosis of two conditions such as auricular extrasystoles and an early auricular fibrillation. As the prognosis in these two conditions differs rather widely an accurate diagnosis is essential, and it seems generally agreed now that no other means can make this differentiation as accurately as can the electrocardiogram.

(b) *Prognosis.*—In no other department of cardiac work is the electrical tracing of such use as in the estimation of a prognosis. We have discussed the P. wave above and the information supplied by the study of this wave is of very great value in prognosis. It shows us the relation of the auricular contraction to that of the ventricle, and from its position we can learn the latent period of the ventricular muscle; this is very important information as, from it, we can see if the heart is getting sufficient rest. This wave also shows us where the wave of contraction is starting and gives an idea of the conducting properties of the Bundle of His. It also gives an idea as to which side of the heart, if either, is doing the greater amount of work.

Another wave of great significance is the T. wave, which has also been discussed above, and, as an index of the condition of the myocardium, we have no surer guide. It has long been recognised that in heart disease the state of the myocardium is of first importance and the harm that any valve lesion can do depends entirely on the amount of resistance that the myocardium can afford. Without an electric tracing we have no sure means of estimating the reserve power of the myocardium and, in a study of the characters of the T. wave we find the necessary information. In the treatment of cases of heart block the electric tracing gives valuable information in that it tells us if the waves which begin to appear as the block is being removed are due to contractions of the whole heart or are only spasmodic contractions of some of its chambers. This is useful information as it tells us if our treatment is doing any good.

(c) *Estimation of Treatment.*—The efficiency of any treatment is shown by the return of the heart's action towards the normal state and in this recovery of the heart the greatest change is seen in the efficiency of the heart muscle. Bruits are very variable and are often over-estimated in importance, as the attention which is attracted by the bruit is diverted from its proper object, that is, the consideration of the efficiency of the heart as a whole. In this respect the electrical tracing gives us the best picture of the heart as a whole, it shows us the relative amount of work done by each part of the organ, and, what is most important of all, it estimates the reserve power of the heart and tells us how much "overtime" the heart can be reasonably expected to do. This equips us best for giving an answer to a question a heart patient frequently asks, *i.e.*, "How long am I going to live?" and should save us from giving, too often, the noncommittal and ambiguous replies, so often given to the earnest questionings of our patients.

The object of this article has been to try to show some of the conditions in which the electrocardiogram is especially useful, and also that its determinations are both qualitative and quantitative. In the examination of adult hearts its use is chiefly in diagnosis, and estimating prognosis, and therefore regulating treatment, but a much greater sphere of activity likely to produce a good result, is in estimating the cardiac efficiency of children and young adults. The instrument then assumes importance in the field of preventative medicine which is one of the most logical forms of medicine. Preventative efforts in medicine, concentrated on the first two decades of life, should "bear fruit an hundredfold" and, in this work, the electrocardiogram will prove itself to be a very valuable asset.

A Case of Perinephritic Abscess.

THE following case is of interest owing to the difficulty of diagnosis in the earlier stages, a complication masking the true seat of the trouble.

Mr. O——, aged 36, a well built healthy looking man, who had never had any serious illness, with an excellent family history, and living in comfortable surroundings, consulted me on 15th November, 1920, complaining of a pain in the right side. The pain was referred chiefly to the base of the chest and to the loin, and was said at times to radiate to the right iliac fossa.

Examination failed to reveal any signs of pleurisy or appendicitis, nor could anything be found in the hypochondriac region. There were no dyspeptic symptoms, the bowels and micturition were regular and the urine normal.

There was a history of a "rick" to the back a few weeks previously, the patient having slipped while supporting a heavy weight, but the temperature, 101°, pointed to something more than strain.

For the next three days the case was watched, the temperature ranging from 99° to 101°, the pulse running about 85, and the respirations about 22. There was a constant slight cough and an occasional stabbing pain on deep inspiration.

The case appeared to be one of diaphragmatic pleurisy, and on the fifth day (20th November) a rub was detected at the right base in the anterior axillary line. The temperature was now ranging

from 100° to 102°, the respiration had quickened to 26, and the pulse averaged about 90.

A few days later the rub disappeared, and there was evidence of effusion at the right base, mostly confined to the anterior axillary and sub-mammary regions. The case was watched for a few more days in hopes that resolution would set in, but the temperature continued to creep up, reaching 103° at night, and the possibility of empyema had to be considered.

On November 27th Dr. Firth kindly saw the patient with me and an exploratory puncture was made. Blood-stained fluid, but no pus was withdrawn. On microscopical examination of the exudate no organisms were found, and a culture proved sterile. The cellular elements showed a preponderance of small mononuclear leucocytes, the polymorphs being scanty and not degenerated.

The patient was removed to the Cottage Hospital on 30th November, his temperature ranging from 101° to 103°. Respirations about 30, and pulse about 100. A blood count showed a leucocytosis of 11,000, the differential count being practically normal.

On the occasion of his visit on 27th November, Dr. Firth had called attention to the tissues over the lower ribs and the flank on the right side, which were more resistant than those on the other side, presenting a quasi-solid œdema, and considered this strongly indicative of suppuration. Preparations were accordingly made for finding and evacuating the supposed empyema, and on December 3rd, Dr. Charrington Wood kindly administered an anæsthetic. Exploratory punctures were made, but nothing more than blood-stained fluid, apparently confined to a small loculated area could be found and further operation did not appear justifiable. While still under the anæsthetic the right hypochondrium and flank were carefully palpated, but nothing abnormal was detected.

For a day or so the temperature was somewhat lower, but soon was ranging again from 100° to 103°, the respirations remaining as before, but the pulse increasing in rate and deteriorating in quality. The urine, which was examined periodically, remained normal. It was not till some ten days later that it became obvious that the seat of the suppuration was below the diaphragm, the tissues in the flank becoming more tense and ultimately the skin becoming reddened.

The patient was now moved to King's College Hospital, under the care of Dr. Firth, and from him transferred to Mr. Everidge who operated, opening and draining an abscess in the retroperitoneal tissues in the neighbourhood of the kidney. This organ was palpated at the time of the operation and appeared normal.

The patient made an excellent recovery. Since returning to his home he has gained over a stone in weight, and now looks the picture of health.

A culture from the pus evacuated showed the infection to have been staphylococcal, possibly derived from the time (some months previously) when he had suffered from a bad boil on the arm.

Dr. Firth kindly saw the case more than once in consultation with me and I am indebted to him and to Mr. Everidge for permission to make use of their notes on the progress of the case while in King's College Hospital.

G. H. PENNELL.

Artificial Respiration in Apnœa during Anæsthesia.

I should like to call the attention of readers of the Gazette to the simplest and most effective of all methods, which was shown to me in France during 1916, by Mr. Seton Pringle of Dublin. The proceedure is simply to place the face-piece of a Clover's inhaler, or gas apparatus, over the patient's mouth, and inflate his lungs with one's own expired air about ten times to the minute. It is undoubtedly an old method, but it appears to have been lost sight of. I have never seen a case which did not respond rapidly to this treatment, even cases which were giving rise to serious anxiety, and ones in which the ordinary methods had already been tried without any success. Being one of the worst anæsthetists in the B.E.F. I had reason to be thankful for its help on a good many occasions.

I do not pretend to explain why it should be so much more successful than the usual methods, but one reason must be that the lungs are really expanded to their full extent, while the methods in common use do not cause any descent of the diaphragm, and produce at best a very feeble degree of ventilation. Besides, the movements they reproduce are the abnormal ones, costal rather than diaphragmatic movement, forced expiration and a passive return to the resting position, rather than the normal inspiratory movement followed by a passive return. Then again, by this proceedure the lungs are filled with an air containing sufficient oxygen, and a high percentage of carbon dioxide, and will therefore supply the normal stimulus to the respiratory centre. Not least, the fully expanding lungs must exert a positive pressure on the heart, while the moment they are allowed to collapse, the maximum negative pressure in the thorax will bring its filling effect to bear on the great veins.

W. H. OGILVIE.

Guy's Hospital.

Abstract of Summary of Anæsthetics and Operations for the Year 1920.

THE number of cases in which general anæsthetics were administered was 7,908, among which were 73 intratracheal insufflations of ether, and 6 of ether and C.E. Spinal analgesia was also employed on 30 occasions, and on 55 occasions spinal analgesia followed by a general anæsthetic. On one occasion intrapharyngeal ether + C.E. was employed. The total number of operations was 7,619 in wards (Bright Ward excepted), Special Departments, Out-Patient Departments, and Surgeries. There were five deaths under anæsthesia.

There have been 7,753 cases of general anæsthesia in the Dental Department; 6,390 under nitrous oxide gas, and 1,363 under ethyl chloride.

Operations done on the medical side are entered under the assistant surgeons corresponding to the physicians or assistant physicians in charge of the wards, the table below showing how many operations are actually performed in these wards:—

ANÆSTHETICS.

A.C.E.	19
C.E.	1133
Chloroform	159
Ether (including gas and ether)	410
Gas, and gas and oxygen	1353
Intratracheal insufflation of ether	73
Intratracheal insufflation of ether and C.E.	6
Intrapharyngeal ether + C.E.	1
Spinal analgesia	30
Spinal analgesia followed by a general anæsthetic	55
Other anæsthetics and Sequences	4699
	7938

ADMINISTRATION OF ANÆSTHETICS.

Staff Anæsthetists	1824
Visiting Staff	260
House-Officers	5106
Other Qualified Men	748
	7938

OPERATIONS.

Tabulated According to Wards and Departments.

Astley Cooper	271
Cornelius	234
Lazarus	308
Job	301
Naaman	322
Luke	287
Patience and Samaritan	327
Evelyn	181
Charity	322
Dorcas	390
Lydia	336
Martha	347
Eye Wards	880
Addison	58
Mary	30
Stephen	73
Esther	43
Queen Victoria	503
Miriam	9
Isolation	13
Out-Patients	1824
Front Surgery	434
Back Surgery	104
Nurses' Sick Room	22
	7619

Turning to the general wards it may be noted that the totals of operations are as follows:—

Surgeons	777
Assistant Surgeons	912
Specialists	117
House-Surgeons and Assistant House-Surgeons	638
Dressers	409
	2853

The remaining 778 operations, bringing the total up to 3,631 were performed by other operators.

It should be remembered that no account is taken of operations done either under local anæsthetics or without anæsthetics at all.

Operations in the Obstetric Department (Queen Victoria and Patience Wards) number 522, of which 252 were performed by the Obstetric Surgeons, 77 by the Obstetric Assistant, 80 by the Gynæcological Assistant, 106 by the Obstetric Residents, while 7 operations were performed by other operators.

The operations upon Ophthalmic cases in the wards number 163, of which 104 were done by the Ophthalmic Surgeons, 12 by the Ophthalmic Assistants, 34 by the Ophthalmic House-Surgeon, 6 by Ophthalmic Dressers, and 7 by other operators.

There were 722 operations for Throat and Ear Diseases in the wards, 388 by Surgeons, 166 by Clinical Assistants, 116 by the House-Surgeon, 32 by Dressers, and 20 by other operators.

In the Orthopædic Department 127 operations were performed, 1 by Dressers, 93 by the Surgeon of the Department, 32 by the Orthopædic Registrar, and 1 by the Clinical Assistant.

In the Genito-Urinary Department 73 ward operations were performed, 63 by the Surgeon, 3 by Dressers, and 7 by other operators.

In the Venereal Department there were 7 ward operations performed.

Twelve operations were performed on patients in Skin beds.

In the Front and Back Surgery 538 operations were performed, 344 by House-Surgeons and Out-Patient Officers, 176 by Dressers, and 18 by other operators.

In the General Out-Patient Department 470 operations were performed, 350 by Dressers, 73 by Assistant House-Surgeons, 4 by Surgeons, and 43 by other operators.

In the Special Out-Patient Departments, there were 1216 operations upon Throat and Ear cases, of which 29 were done by the Surgeon, 315 by the Clinical Assistants, 215 by the Ophthalmic House-Surgeon, and 564 by Dressers, while 93 were by other operators.

One operation was performed by the Surgeon in the Eye Department.

In the Genito-Urinary Department 4 operations were performed, 1 by the Surgeon, and 3 by other operators.

Two operations were performed in the Skin Department, 2 operations in the Children's Department, and 1 operation in the Venereal Department.

In the Orthopædic Department 128 operations were performed, 29 by the Surgeon, 82 by the Orthopædic Registrar, 2 by the Clinical Assistant, and 15 by Dressers.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

From a Guy's Man in Abysinnia.

SIR,—There has never appeared in your columns a letter from this part of the world and as I have the honour to represent not only Guy's but alas the British Medical Profession in this particular Empire, I am your only possible correspondent. Somehow this country has attracted fewer medical men from Europe than any other country of its size in the world. Possibly this is because there is hardly a bare living to be made here despite the natives' passion for drugging himself. Prior to the influenza epidemic of 1918, there were no less than eight men of medicine in this town—French, Italian, Greek, Austrian, German, Russian, but no Englishman. In one month five of these died and of the remaining three only one was able to carry on.

From a medical point of view there is one disease here which has an interest and a frequency unequalled in any part of the globe. Perhaps I am wrong in calling Tæniasis a disease—it is a *habit*. No selfrespecting Abyssinian worthy of his country is without a tape worm. I have met many Abyssinians, from the highest in the land to the lowest and most miserable of slaves, but I have yet to find an authentic case of absolute freedom from tapeworm. The cause, of course, is to be found in the national habit of eating raw beef, especially on feast days, and the partiality of all for the tongue and the tissues around it. The cysticercus is often known as the evil eye, but I have not yet found that it is connected in the mind of the native with the hideous tapeworm that henceforth becomes his life-long companion.

After 10 or 12 weeks portions of the mature worm begin to appear on the loin cloth and the host then takes steps to get rid of his guest.

This process consists in taking a large dose of one of the many vermifuges which grow here, and then retiring from public view for a day or two. The second day is required to recover from the first. All one's personal servants, clerks, watchmen and stable boys, etc., require leave every ten weeks throughout the year in order to take "kosso." Native drugs hardly ever seem to bring away the head and I fancy the worm is left, as a rule, with 20 or 30 segments still attached to the head—perhaps an inch or an inch and a half in length. Many authorities hold that the creature is solitary, but in my experience a multiple infection is far more often met with than a single worm. On one occasion I secured from one of my servants, three hours after the administration of 2½ drs. of Extractum Felix Mas, no less than 9 heads and about 120 feet of worm!

While all Abyssinians give hospitality to the Tænia Saginata, and many entertain the round worm all their lives, it seems to be a point of honour with them not to meet their Maker with a tapeworm inside them. Kosso is always taken by an army before going into battle and it may even be necessary to postpone a big fight for this purpose. A curious incident came to my knowledge the other day. Seven men were condemned to death for blood feud murders by the Regent Ras Tafari. The sentence was pronounced last Friday and executions usually take place on Saturday at the big market. Subsequently I heard from the Ras that the spokesman of the seven begged him for three days' grace in order that he and his friends might take kosso. The Ras granted them leave and I fancy they will now not be done to death till next Saturday.

While on this subject may I ask if any Guy's man knows of a palatable and infallible tæniafuge. I regret to say I do not.

Among less common diseases, but nevertheless all too common and all too fatal, are smallpox, typhus, and pneumonia. Abyssinia is for the most part a

high table land, cut by rivers of which few reach the sea where the climate is hot and damp. This town is only a few feet under the 8,000 mark and, in consequence, the climate is highly agreeable for Europeans. It is true there are several drawbacks, for naturally a good deal of compensation is required of the heart and lungs owing to the low partial pressure of oxygen. But sunstroke, so common north of here, is practically unknown in Adis Ababa, and a double terai takes the place of the tropical helmet. At this time of year the cold east winds are very trying and produce a lot of pneumonia and bronchitis to both of which the native is extremely susceptible.

One disease is remarkable for its non-existence. I have yet to see or hear of a case of Phthisis in a man who has lived here all his life. It is true it occurs, but only in persons who have developed it in the low country and who come back here usually to die of it. On the other hand other forms of tuberculosis are comparatively common.

I fancy, Mr. Editor, my letter has already exceeded the lengths you allow, and my notes on some other diseases, which have quaint local peculiarities, I must reserve for another occasion.—I am, Sir, Yours faithfully, D. A. DYER SHARP.

British Legation,
Adis Ababa, Abyssinia.
5th January, 1921.

The War Memorial.

SIR,—When I wrote the letter which you published in your penultimate issue, I had no intention of carrying on a prolonged correspondence concerning the ethics of tree-felling. Since, however, you printed some purely personal conversation of mine in "Passim," I think that perhaps I may have some claim to trespass further on your space.

I was pleased to see that your plea for the "thining" of the "forest" had met with little sympathy. It shows that the majority of Guy's men still are not slaves to utilitarianism. My pocket Webster offers no information concerning the verb "to thine," as it does not deal with technical words, but presumably, from the context, it has something to do with cutting down trees.

The wards you mention as suffering from the effects of exuberant vegetation happen to be the brightest and, in summertime, the coolest in the Hospital. As regards the rooms in the north-west turret of the College (all of whose rooms are inexpressibly gloomy), they are the lightest in the whole building—even the exacting taste of an Editor choosing them as most fitting to be his sanctum. Thirdly, at least one Warden's family deeply deplore the loss of the one thing of beauty opposite their windows, with no prospect of its being adequately replaced. And lastly, your veiled suggestion that the dinginess of Bermondsey is due to excessive foliage is too futile to answer.—Yours (quite friendlily), "RESIDENT."

The College.
February 5th, 1921.

SIR,—At the corner of Wood Street, in Cheapside, there is a tree, which a hundred years ago inspired the poet's song, and which today still cheers the hearts of thousands passing by. And though the ground on which it stands is very valuable, there are few of us who could wish to see it otherwise employed. I do not know who is responsible for this act of grace; presumably it is the City Corporation or one of the business houses round about.

But here at Guy's—a centre of learning—an appreciation of nature would seem to be at a discount, if we can judge from "Passim." And it is to register my protest against your Editorial scheme of cutting down the plane trees in the park, that I now write. For to some of us these trees are a grateful sight at all times and seasons, and I would ask you to consider the residents of the future cooped up in Guy's during the long summer months. Picture him sitting on a deck chair in the park and looking at the building all around; there will be nothing then to charm his visual cortex, but bricks and grass —*and the memory of the trees*.—I am, Yours, etc.,

X. Y. Z.

Guy's Hospital, S.E. 1.

The Conservation Room.

DEAR SIRS,—I see in the admirable address that Mr. Frank Pearce delivered on "Guy's and its Dental Surgeons," that he is reported to have given me the credit of devising the name of the "Conservation Room" but I believe it was the late Mr. N. Davies-Colley who got us over a real difficulty in naming the Conservation Room. There seemed to be some risk that it would get confused with Conversation Room, and even our printers fell into that error at first.—I am, Dear Sirs, Your sincerely,

F. NEWLAND-PEDLEY.

[N.B.—The above mistake has not yet died a natural death; on the very day we received Mr. Newland-Pedley's letter we noticed a telegram in the Front Lodge addressed to the Conversation Room. —Ed.]

Guy's Men at the Middlesex Hospital.

DEAR SIR,—I hazard a guess that Dr. Bennett has still more company there than you deemed. Not only Mr. Sampson Handley,—were not Mr. Greeves,

the Ophthalmic Surgeon, and Mr. Blundell Bankhart, the Orthopædic Surgeon, christened at Guy's too?

St. Margarets, RICHARD GILLBARD.
Dean Road,
Willesden Green, N.W.,
Telephone, Willesden 1514.

DEAR MR. EDITOR,—Mr. A. S. Blundell Bankart, who has recently been appointed Orthopædic Surgeon to the Middlesex Hospital, is also an old Guy's man.—I am, etc., ALAN H. TODD.

83, Portland Place, W 1.
February 15th, 1921.

The Kent Hughes Challenge Cup.

SIR,—The GAZETTE of April 2nd, 1910, records that Guy's, the holders of the Kent Hughes Challenge Cup (1909) managed to prevent London from securing it. Also we held it 1911 and 1913, if not 1912, which I have no record of.

Guy's, 1909, 1910, 1911, 1912, 1913, 5 years.—Your truly, A. P. L. JOHNSON.

Forest Edge,
Wootton,
New Milton, Hants.
February 5th, 1921.

The following letter has been received from an anonymous altruist by Prof. Eyre.

To The Professor of Research,

I have seen that you are still trying to locate the influenza microbe. Have you ever looked for it in the tobacco and cigarette stuff that is sent through the air in such quantities at present? If you are a smoker don't let your selfish love of a perfectly dirty and useless habit deter you. The good you might do would compensate any self-denial on your part. It may also be the cause of consumption. How can air so full of the beastly smoke out of men's dirty mouths be good to breathe? —With best wishes for success, Yours,

TO BENEFIT MANKIND.

Waterford.

Memorial to Dr. Burrows.

DEAR SIR,—The Council, the Delegacy and the Professorial Boards of King's College have resolved to found a Memorial to the late Dr. R. M. Burrows, who guided the fortunes of the College with such brilliant success during his seven years' tenure of the office of Principal, and whose death on May 14th of last year was a matter of such deep regret to his many friends and admirers within and without the College.

A Joint Committee of the various bodies has been appointed, and has been authorised to issue an appeal and to take all the steps necessary for giving effect to the proposal. It has been decided that the Memorial shall take the form of a Tablet to be erected in the College Chapel, together with a Ronald Burrows Prize, Exhibition or Scholarship to be awarded annually to a student of the College who had distinguished himself in the field of Greek studies. It is hoped that the funds raised will be sufficient to make possible the foundation of a Scholarship of such value as to afford effective assistance to promising students in the prosecution of their Greek studies, and so further materially that branch of learning which our late Principal had so much at heart.

From those who are unable to give large donations small sums will be gladly received, as it is desired to emphasise the wide-spread regard felt for Dr. Burrows. A complete list of subscribers, but without the amount of their subscriptions, will be exhibited in the College, and will be sent to all subscribers, together with a statement of the total sum raised, and of the precise form the Memorial will take.

The Hon. Eleanor M. Plumer has undertaken the office of Honorary Secretary. Professor H. G. Atkins has consented to act as Honorary Treasurer, and subscriptions may be sent to him at the College. —Yours faithfully,

A. F. LONDON, Chairman of the Council.
HAMBLEDEN, Chairman of the Delegacy.
ERNEST BARKER, Principal.
W. R. MATTHEWS, Dean.

Notices.

The Annual General Meeting of the Students' Club will be held on Friday, February 25th, at 4 p.m. N. MUTCH, *Hon. Sec.*

Dr. J. Howard Munsey, C.B.E., will deliver a lecture on "Morbid Dental Histology," in the Anatomical Theatre, on Thursday, March 3rd, at 4 p.m.

Appointment.

Alan H. Todd, M.S., B.Sc.Lon., F.R.C.S.Eng., to be Assistant Surgeon to the Queen's Hospital for Children, Hackney Road, E. 2.

Papers by Guy's Men.

Frank J. Pearce, L.D.S., D.D.S. Guy's and its Dental Surgeons.—*British Dental Journal*, xlii., p. 89.

D. W. Samways, M.D., D.Sc., M.R.C.P. Dilatation of the Heart.—B.M.J. February 5th, 1921, p. 188.

Lawrie McGavin, F.R.C.S. Case of Diffuse Hypertrophy of the Breasts.—Proc. Roy. Soc. Med., xiv., Clinical Section, p. 21.

W. H. Ogilvie, M.Ch., F.R.C.S. (1) Case of Strangulation of the Small Intestine by a Band, with Unusual Absence of Symptoms.—*Ibid.*, p. 27 (2) Case of Enlarged Ischial Bursæ.—*Ibid.*, p. 29.

A. F. Hurst, M.D., F.R.C.P. Hysterical Blindness of Four Years Duration cured by Psychotherapy.—*Ibid.*, p. 30.

R. P. Rowlands, O.B.E., M.S., F.R.C.S. Case of Diaphragmatic Hernia.—*Ibid.*, p. 34.

H. W. Barber, M.D. Two Cases of Psoriasis treated by Danysz's Method.—*Ibid.*, Sec. of Dermatology, p. 24.

T. B. Layton, M.S. Paralysis of Recurrent Laryngeal Nerve after Thyroidectomy.—*Ibid.*, Sec. of Laryngology, p. 24.

Montagu F. Hopson, L.D.S. (1) Complete Absence of Deciduous and Permanent Teeth. (2) Twenty-one Unerupted Teeth in the Mouth of a Woman, aged 49.—*Ibid.*, Sec. of Odontology, p. 23 and p. 24.

H. L. Messenger, M.C., M.R.C.S., L.R.C.P., L.D.S. Case of Unerupted Teeth in a Woman aged 80.—*Ibid.*, p. 26.

F. A. Doubleday, L.R.C.P., M.R.C.S., L.D.S. The Acid Reaction of Certain Material used in Filling Teeth.—*Ibid.*, p. 35.

J. Lewin Payne, L.R.C.P., M.R.C.S., L.D.S. An Artificial Velum for Congenital Cleft Palate.—*Ibid.*, p. 36.

A. W. Sheen, C.B.E., F.R.C.S. (1) Case of Fibrous Union of Femur, p. 59. (2) Case of Flail Shoulder.—*Ibid.*, Sec. of Surgery, p. 60.

E. G. Slesinger, O.B.E., M.S., F.R.C.S. An Unusual Case of Submaxillary Gland Infection in an Infant; Removal; Recovery. *Clinical Journal*, l., p. 44.

J. B. Parfitt, M.R.C.S., L.R.C.P., L.D.S. Perforation of the Second Lower Molar by the Mandibular Nerve.—*Brit. Dent. Jour.*, xlii., p. 147.

Reviews.

The Care of Human Machinery. By R. M. Wilson, M.B., Ch.B., etc. (Oxford University Press: Messrs. Hodder and Stoughton.) Price 10s. 6d. net.

In these days of Re-construction and Re-adjustment, "Efficiency" has become a battle-cry; whilst the necessity of realizing the workers' angle of vision is being forced willy-nilly upon our administrators by the continual industrial disputes. Whatever views one may hold on the merits of the controversy, it is futile to imagine that output—the consummation devoutly to be wished—is governed solely by standards of adequate wages and hours.

The happily chosen title of Mr. Wilson's book will appeal to the medical world, as well as to the more academic and visionary eugenists and sociological enthusiasts. It is stated by the author in his preface that "The elements . . . are set forth . . . in language as simple as possible," and that "the volume is intended not only for medical men, but also for employers of labour and their workers."

Whilst recommending this easily-read work to all our readers, we reserve the power of criticizing, to the extent of hoping, that, in the future, the author will deem it worth his while to re-write this stimulating and suggestive hand-book so as to fill the classic vacancy in industrial medical literature.

We are pleased to note the stress laid upon the intimate relationship between the medico and the workman; and hail this opportunity of emphasizing the fundamental position of all doctors, in aiming at reassuming the Empire's world-dominance, by helping to stimulate the heart of our prosperity—"Production."

The subject is of such an importance, that we have no hesitation in urging all our readers to encourage further interest in this somewhat neglected side of routine doctoring by a careful study of this book followed—we trust—by a deeper interest in the more technical influences on the healthy human body as a vital factor in the new Industrial Movement.

Football.

RUGBY.

Many Rugby men of the Hospital, some of whom are now in New Zealand and South Africa, will remember Mr. Peter Harris, for many years Hon. Sec. of Catford Bridge Rugby F.C. This gentleman died at the age of 73, at the Scottish village whence he retired after leaving his post in the offices of Messrs. Donald Currie & Co., in the last week of January. Guy's men may remember him as being called "Port" Harris and they may remember the reason. A well known figure, with high hat and pointed beard, on all Kent football fields, he was

greatly missed on going back to his native land, and in the village in Scotland he became President of the local Football Club and a Scoutmaster. Last summer on his arrival in London to visit a friend at Catford, he actually walked with his hand luggage from Euston to Catford.

One by one the Sportsmen leave us, and Mr. Harris was one of the best of them.

GUY'S v. LONDON WELSH.

Before a good number of spectators this match took place at Honor Oak Park, on February 5th. The Hospital had an excellent side out and started in such promising fashion that 15 minutes only had gone by and they were 3 tries, or 9 points, to the good. The first try was the result of excellent passing from the scrum base to the right where Steyn was and he gained the touch. Another excellent try came from J. A. Krige, the passing was again well done. E. E. Neser attempted to convert both these tries, but his judgment was a little at fault. Sad to relate P. K. Albertijn was now playing with an arm tucked up, owing to a damaged shoulder. F. W. Reitz, therefore came out to assist the backs. Albertijn doing what he could. With one hand he tapped on a pass from Van Schalkwijk to Reitz, who gave to J. A. Krige, and again the centre threequarter scored. This time Van Schalkwijk failed with the attempt at conversion. In the meantime the Welsh had not been lookers on, they had tackled well, in fact better than our men, who do not yet go low enough or hard enough. Steyn has improved no end in this respect. Doherty and Reitz always were good, but the others should take to heart the lesson that Taylor gave them. Man after man missed W. L. Michael, the big Welsh forward, but not so Taylor. Evans had very hard lines in not being given a try for his score by the corner flag. J. T. Jones, however, put on a good three points before half-time, for the visitors following up his own punt very swiftly he got over before the defence appeared to realise danger.

The second half opened with Albertijn absent, then he reappeared and secondly retired, though very diffidently; once, before his final departure, he broke through beautifully, but lost the ball and again Daneel broke through, no one to pass but the back, he started to wonder as he got up his pace, he neither swerved nor passed to those running with him, but kicked aimlessly ahead, hoping that fortune would be kind, it wasn't and a fine chance was lost. Marais had a clear run, here again he hadn't the confidence of his speed. The referee now burst forth with penalties for everything we did. Unhesitatingly, and one may say unblushingly, he gave free kicks against us, and quite spoilt the game. Spectator and player all were aghast at the decisions and admonishments. Guy's players were undoubtedly quite put off their game, and what should have been a glorious battle was turned into a Rugby seminary. Whistle and free kick to follow, was the ending to most bouts of play, like a full stop ends a sentence, and none could understand half the awards or penalities. At length J. A. Krige crossed the line again, and the scoring totalled Guy's 4 tries (12 points), London Welsh 1 try (3 points).

Guy's Team.—W. Olivier, C. L. Steyn, J. A. Krige, P. K. Albertijn, A. Daneel, F. Bekker, J. G. Van Schalkwijk, W. D. Doherty, F. W. Reitz, A. H. Shelswell, C. Marais, A. H. Van Zyl, E. E. Neser, W. H. Taylor, R. R. Macintosh.

GUY'S HOSPITAL v. CARDIFF.

On Wednesday, February 9th, 15 brave Guy's men departed from Paddington by the 8.45 a.m. for Cardiff. They were brave because they went to tackle Cardiff, on their own ground, before their own crowd, and they went without Albertijn, who is crocked, and Van Schalkwijk, who has played in practically every match since he came up to Guy's, a very real pattern of keenness. Doherty, Reitz, Van Zyl, Neser and Macintosh were also prevented from making the journey. Steyn played half back by way of a change, and T. A. Shaw, generally looked upon as a full back or threequarter, played nominally as a forward, really, where he thought himself most useful. Mackenzie of the 2nd XV. filled a place, and those excellent sportsmen, ever ready to lend a hand (or a foot), L. K. Watson and F. J. Biddle also came into the pack. Well, Cardiff had a very good side out indeed. Wallace, who tried to get swallowed by England's full back three weeks ago, and who is an Irish International, Johnson, Clem Lewis, who are Welsh Internationals, as well as others well known in Welsh football, gave us something to go on with. There was only one try scored against us and this was one of those things that happen in the best regulated matches. Sullivan, the Cardiff full back, got going and ran right down the touch line, punting on when reaching Olivier and securing again to cross for an unconverted try. This was just before half-time. The two centres, Graham-Davies and J. A. Krige, played splendidly. In fact the whole team proved themselves great defenders in this match at any rate. The Cardiff pack gave us so much to do that the ball seldom reached our backs and the opportunities of attack were very few indeed. The game was quite a good

one and congratulations are due to the Guy's XV. who so gamely turned out, with no fear of the tall problem at their journey's end, and who came back, beaten it is true, but only by the smallest margin. Wait till Cardiff come to Honor Oak Park, and then we'll show 'em, on our ground, before our crowd, and we hope by that time the new covered grand stand so badly wanted, will be erected.

Guy's Team.—W. Olivier, H. Van Heerden, J. A. Krige, H. Graham-Davies, A. Daneel, F. Bekker, C. L. Steyn, C. Marais, R. F. H. Duncan, A. H. Shelswell, L. K. Watson, F. J. Biddle, W. H. Taylor, C. MacKenzie, T. A. Shaw.

ASSOCIATION.

GUY'S "A" v. BANK OF ENGLAND "A."

Played at Chiswick, on Wednesday, February 9th, when a hard and interesting game resulted in a win for Guy's by four goals to one. Guy's started two men short—owing to exams.—and for a long time were on the defensive, but Mackeith saved well on several occasions. The Bank scored first from a penalty, but Guy's soon responded with a good shot from Payne. After this with a full side Guy's pressed and were chiefly on the attack for the rest of the game, scoring three times, through Palfry, Gonsalves and Hewetson from a penalty.

Guy's Team.—Mackeith, Wakeford, Fripp, Robertson, Painter, Hewetson, Kendrick, Palfry, Crisp, Gonsalves, Payne.

GUY'S "A" v. ST. THOMAS' "A."

First Round of Inter-Hospital Cup (Junior).

Played at Chiswick, on Wednesday, February 9th. St. Thomas' kicked off and after some mid-field play Guy's pressed, but the inside forwards lacked the dash to turn their chances to good account; with occasional rushes from Thomas' this continued for the first half. Danino and Sennitt were conspicuous in holding up the Thomas' forwards, and during this half they only scored once, from a good shot from their inside left. In the second half, with Robertson coming up to the forward line, the forwards played with much more life, but still they did not score till about a quarter of an hour of the second half had gone; then Robertson put the ball on to the goal line and Graham shoved it through; Gonsalves then broke away and scored, and soon after the same player headed a goal from a corner kick taken by Kendrick. The remainder of the game was contested stubbornly, with both sides attacking in turn—but the end came with no further addition to the score.

Guy's Team.—Mackeith, Sennitt, Fripp, Robertson, Danino, Hewetson, Kendrick, Palfry, Graham, Gonsalves, Payne.

Sennitt and Danino were conspicuous in the defence and Gonsalves and Kendrick in the forwards, where more steadiness in front of goal is needed.

Other Results:

Guy's "A", 0; King's College "A," 2.

LONDON UNIVERSITY CHALLENGE CUP.

THIRD ROUND.

GUY'S HOSPITAL v. BIRKBECK COLLEGE.

The above match was played at Honor Oak Park on February 1st, and resulted in an easy win. Guy's fielded a full team and at once began to attack, but had the misfortune to lose Van Geuns after about fifteen minutes' play.

The final result was 10—0, goals being scored by Williams (5), Trott (2), Morgan (2), and Couch.

Guy's Team.—Hardy, Wakeford, Riddolls, Painter, O'Meara, Couch, Van Geuns, Nicholls, Williams, Trott, and Morgan.

Guy's meet the London School of Economics in the Semi-Final—date and ground not yet fixed.

INTER-HOSPITAL CHALLENGE CUP.

FIRST ROUND.

GUY'S v. ST. THOMAS'S.

Guy's were without Van Geuns when this match was played at Honor Oak Park on February 7th, 1921. Our forwards at once attacked, and at the end of four minutes' play Williams and Trott had both scored. Williams scored again before the interval.

In the second half play was much more even and both sides scored once. Result, 4—1. Scorers Williams and Trott (2 each).

Other First Round Results.—University College Hospital 3, London 0; Bart's. 5, Mary's 1; Middlesex w.o., King's scratched.

The grounds and dates of the Semi-Finals of the Senior Cup are:—

Monday, February 21st, 1921, at St. Thomas's, Chiswick—University College Hospital v. Bart's.

Wednesday, February 23rd, 1921, at St. Bart's., Winchmore Hill—Guy's v. Middlesex.

Other Results:

February 12th, 1921, at Honor Oak Park, Guy's 1 (Williams), King's College 1.

ED.—M. E. S.

GUY'S HOSPITAL GAZETTE.

VOL. XXXV., No. 852.] MARCH 5, 1921. [NINEPENCE.

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Passim.

IT was with the greatest approval that we noticed some months ago that the notice-board in the colonnade, near Cornelius, had been removed for the renovation which it had long required. In due course it was replaced, its paint fresh, its windows all in place and all clean. We looked forward to the pleasure which we would derive from being able to read, in comfort, the divers notices with which the Medical School Office and the secretaries of the various hospital societies regale us. But this pleasure was not vouchsafed us. Some genius hit upon a brilliant scheme. It was decided that all notices should be posted, not inside the notice cupboard (this perhaps had been the original but antiquated idea of the designer of the board), but upon the wooden framework outside. Our readers will at once see the great advantages offered by this scheme. Firstly, it saved cleaning the windows of the notice-board, since these, being behind the notices, might be as dirty and as opaque as it is possible for windows to be in the Borough, without detracting from the value of the notices. Secondly, it saved the original posters of notices the trouble of removing their intimations after they had served their purpose. For, fanned by every breeze that blows, these poor notices flutter to and fro, night and day, until, sooner or later, some stronger gust of wind hurrying down the colonnade snatches at them and tearing them from their moorings, whirls them off out into the Park, and having chased them in and out among the trees in wanton frolic, it at last deposits them ignominiously there among the dusty débris of broken masonry.

Yet we cannot but think that though perhaps more troublesome, it would still be better in the end if the authorities found it possible to carry out the few poor suggestions which we beg to offer them. These are that all notices should be posted inside the notice board, that the windows should be kept clean, and that the old time-expired notices should be removed. This last suggestion, we would point out, applies particularly to those notices posted on the opposite side of the colonnade immediately adjacent to Astley Cooper. Here, posted inside the windows and so protected from the rude hand of Boreas, lies many a notice of yesteryear whose day is done, whose function is completed, whose only excuse for remaining is that of historical interest, but which still stays on to obscure far younger yet far more important brother-notices. Let all this jumble be removed and only a few select notices remain posted inside the board, so that he that runs may read

without having to pause to smooth out the fluttering foolscap only to find a notice he has read weeks before.

[Since this paragraph went to press the offending notice-board has been once more removed from its place in the colonnade. We hope on its return to see it put at last to a good use.]

During the last fortnight we have regretfully watched the destruction of Miriam Ward, the last that was left to us of the old Clinical Buildings. Now that it has been razed to the ground, quite an appreciable expanse has been added to the Park, and the four big trees which hitherto have lived a cramped existence, sandwiched in between Miriam, the old massage buildings and the roadway, now stand unfettered in the open. Moreover, now that an uninterrupted view of the new massage block is obtainable, we must confess that the new building is far more impressive, and far less unsightly, than we had anticipated. When the garish colour of its new bricks has been by time toned down, and when, as we hope, grass has been laid and has grown over the site of the old Clinical Buildings, the old Guy's will have given place to a more utilitarian and yet not less pleasing edifice.

There is, however, another building in the Park whose destruction has begun but whose demise we do not in the least regret. This is the Porter's Lodge at the Maze Pond gate, whose unsightly apposition to the Memorial Arch was commented upon in an earlier Passim. We hope that the railings outside will not long survive the destruction of the lodge.

We were glad to see that the committee of medical men in the House of Commons, meeting on February 21st, passed two important resolutions concerning the vexed question of the new medical record cards. Their first resolution embodied the decision which they had come to, to the effect that such a record was likely to result in permanent advantage both to the insured person and to his medical attendant. The second urged the most jealous regard for professional secrecy, the maintenance of which, the committee considered, ought not to be jeopardised. They decided to address a question to Dr. Addison in the House, asking whether the record cards could be demanded by counsel in a court of law. These resolutions are especially interesting in that it will be seen that opinions which were expressed in Passim in January last have been fully endorsed by this influential representative body of medical men.

This subject of medical records is so very interesting to us that we join wholeheartedly with our correspondent "Autolycus" in condemning the authorities, who by their sins, both of omission and commission, prevented our hearing Dr. H. M. Stewart's lecture last Tuesday, on "Medical Records in Private Practice."

A day (Tuesday) was chosen on which one is not accustomed to expect lectures of the Medico-Neurological Clinic, under whose auspices this lecture was being given. Moreover, this particular Tuesday happened to be the Tuesday of the rugby football semi-final—certainly not the best day to choose for a midday lecture. But in spite of this we feel sure that, had the lecture been announced some days previously, instead of on the eve of its intended delivery, many more men would have known of it, and many more would have risked missing either their lunch or their train to Richmond in order to hear it. As it was, so few men were able to appear that the lecture had to be cancelled. We offer apologies to Dr. Stewart, and trust that he will be able to give his lecture at some future date, which we hope will be a more suitable time, and one of which we will receive ample notice.

Guy's are doing so well in the inter-hospital competitions that this year offers prospects of

being even more successful than the record season (so far as cups go) which we had last last year. Our first cup for this season was won for us on Wednesday last by our team of cross-country runners, who defeated King's College Hospital by the narrow margin of one point. Guy's scored 30 points, King's 31, Middlesex being third with 66, and the London fourth with 93 points. It has been by a curious chance our fate to play Middlesex Hospital in each of the three main competitions—Rugby, Association and Hockey. In hockey we beat them in the first round by 2 goals to 1. In Rugby we won by the hugh score of 68 points to 3, a score which does not justly reflect the true nature of the game, for Middlesex, even after having lost two men (the full-back and a forward) from casualties, continued to play a plucky and a vigorous game against a team which gave no mercy, but played at concert pitch to the very end. Under such circumstances the try which Middlesex scored late in the second half of a hoplessly disheartening game, speaks more than any poor tribute which we can make. In the Association game (the semi-final) the first match resulted in a goalless draw. Guy's were unlucky in that they lost Nicholls, their inside right, during the second half. The replay on Thursday last resulted in a win for Guy's by 4 goals to 1. We trust that the Guy's teams will be equally successful in the final matches.

Guy's has lost one of its oldest sons in Professor William Odling, M.B., F.R.S., who died on February 18th, at the age of 91. Professor Odling was the son of a Southwark doctor and received his medical training at Guy's. He qualified M.B London in 1851, and in the same year, at the age of 21, was appointed director of the chemical laboratory of the hospital. Though later in life he was elected a Fellow of the Royal College of Physicians yet he never practised medicine, but confined himself to the subject of chemistry. He was in turn lecturer on chemistry at St. Bartholomew's Hospital, Fullerian Professor of chemistry at the Royal Institution, and Waynflete Professor of chemistry at Oxford. His chemistry was not, however, of the purely theoretical type, for he busied himself with many practical questions such as the analysis of drinking water and the purification of rivers.

We offer no apologies for republishing from an old Gazette the article with which we commemorate the centenary of the death of John Keats. This article is by far the most pleasing, the most instructive and the most comprehensive account, we know, of the years that Keats spent at Guy's. Though Keats completed his course of study and qualified before he abandoned medicine for poetry, yet by many touches in the contemporary tales which we possess of him, we can plainly see that his heart was never in his work and that the surgery of his day was far too brutal for his sensitive nature.

A. T. R.

Pass List.

Conjoint Board.

Final Examination, January, 1921.

Medicine.

J. B. Gregor. L. K. Watson.

Surgery.

G. W. Elkington. *T. W. Turner.
*A. Mikhail. J. T. Jones.
*P. L. Richardson.

Midwifery.

A. Robertson. R. J. Hodgkinson.
L. R. A. Wells. E. Hardy.
*A. Mikhail. J. B. McCann.
A. H. Kassem. A. E. Strawbaun.
M. Hall.

* Have now completed the Exam.

Papers by Guy's Men.

G. Norman Meachen, M.D., B.S., M.R.C.P. The Tuberculous Patient from the Point of View of the Midwife.—*Nursing Mirror*, Feb. 19th, 1921.

A. W. Sheen, C.B.E., M.S., F.R.C.S. (1) On the End Results of Colectomies for Intestinal Stasis.—*British Medical Journal*, January 22nd, 1921.

(2) Oriental Sore.—*Practitioner*, February, 1921.

Sir Charters J. Symonds, K.B.E,, C.B., M.D., F.R.C.S. The Hunterian Oration on Astley Cooper and Hunterian Principles. Delivered before the Royal College of Surgeons of England on February 14th, 1921, the Anniversary of Hunter's Birth.—*Lancet*, February 19th, 1921, p. 359.

R. O. Moon, M.D., F.R.C.P. Heart Disease in Children.—*Clinical Journal*, Vol. L., p. 81.

Some Fractures.

CLINICAL LECTURE BY R. P. ROWLANDS.

Gentlemen,—Fractures will be of great interest and importance to you in general practice, and you will be judged very largely on your success or failure in dealing with these very troublesome injuries; therefore I propose talking to you about some of the general principles of the subject. I bring you no patients, but will show you many pictures on the epidiascope.

Symptoms.—These are usually slight and of little importance, but with severe fractures such as those of the pelvis and femur, there may be considerable shock soon after the injury, and later it is common for the temperature to be a little above normal for a few days. Occasionally thrombosis and pulmonary embolism may occur, and rarely fat globules may escape from the marrow into the circulation and cause fat embolism with delirium and death.

Local signs.—The most important of these are loss of function, deformity, abnormal mobility, crepitus, acute local tenderness, and the radiographic appearances.

Loss of function is generally evident; for instance, a patient with a broken knee-cap rarely tries or is able to walk; but when a fracture is impacted function may be little altered, and this causes difficulty in the diagnosis of Colles' fracture and even of impacted fracture of the neck of the femur.

Deformity is partly due to swelling from effusion of blood, but chiefly to displacement of the fragments of bone, but there may be no displacement, or on the other hand a previously deformed part such as a kypotic spine may be injured, and mislead us to diagnose a fracture.

Angulation, rotation (generally eversion), and shortening are the most important deformities.

Abnormal mobility is important, but it is absent when the fracture is impacted, and difficult to appreciate when the fracture is at or near a joint.

Crepitus is very characteristic, but may be absent owing to impaction, overlapping, or separation of the broken ends. Moreover, creaking tendons or joints may mislead.

Acute local tenderness or pain over the site of fracture is often very valuable, when other signs are absent. A cricketer felt sure he had broken a bone in his elbow, and insisted on a radiographic examination, which showed a fracture of a spur growing up from his olecranon into the triceps tendon. The removal of the spur enabled him to play cricket again (fig. 1).

Radiographic appearances.—The X-Ray evidence is so wonderful and generally so conclusive that we are rather apt to regard it as the only evidence, and thus to neglect the more homely or more generally available clinical signs.

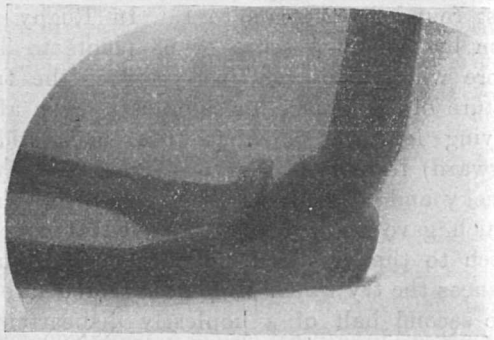

Fig. 1.—Fracture of a spur on the Olecranon disabling a cricketer. The spur was removed.

Really the rays should be used to confirm the diagnosis already made or strongly suspected. They nearly always add accuracy to the diagnosis and give valuable aid in treatment. Therefore it is wise whenever a fracture is suspected to strongly advise the use of the X-Rays, and although the patient may decline, owing to various difficulties and expense, he cannot blame the medical attendant later on for not giving the right advice.

It is also important to insist on an examination in at least two planes, otherwise a fracture may be overlooked. Moreover the whole of the suspected bone should be radiographed. A lady could not walk after a fracture of the femur had joined, and although she saw many consultants in several countries, they did not discover the cause of her disability until at last a more extensive radiograph in two planes revealed higher up an unsuspected ununited fracture, which was then successfully plated by one of our surgeons.

But neither the X-ray apparatus nor the radiographer are infallible, and they occasion-

ally fail to reveal or recognise an existing fracture. A fissured fracture of the tibia without displacement is easily overlooked, and so is a fracture at the neck of the scaphoid of the hand.

A good radiographer, six weeks after an injury of the ankle, thought the X-ray appearances indicated tuberculous disease of the astragalus, whereas an operation revealed a fracture of that bone which had only partly united. It is hardly to be expected that the radiographer can always tell whether there is a fracture of the skull or even of some parts of the spine.

Therefore it is clearly important here as elsewhere to seek all possible signs and to base the diagnosis on all the available evidence and not exclusively on one portion, however good and reliable it may seem to be. For instance, emphysema is a valuable sign of fracture of the frontal sinus, and all the more valuable because the X-rays are not at all likely to shew a fissured fracture in this situation. The same is more or less true of the other sinuses such as the mastoid and the maxillary. I had a blow on the forehead and blood immediately trickled from my left nostril, and on blowing my nose my scalp immediately became emphysematous. Similarly blood far back under the conjunctiva, or escaping from the nose, ear, or mouth, may indicate a fracture of the base of the skull.

Hæmaturia following an injury to the pelvis should make us suspect a fracture of the pelvis with laceration of the bladder or urethra. Paraplegia immediately following an injury is an important indication of a fracture-dislocation of the spine.

Diagnosis.—Fractures have to be diagnosed chiefly from other injuries such as bruises, sprains and dislocations. A bruised hip may be difficult to diagnose from impacted fracture of the neck of the femur, but the absence of shortening and eversion in the former and the X-ray shadow usually enable us to make the distinction with confidence. A dislocation of the elbow may be very difficult to distinguish from a fracture separation of the lower epiphysis of the humerus, but careful attention to all the facts rarely leads us astray.

There is usually a history of an injury, but sometimes this is either wilfully denied or appears too trivial to mention.

The concealment of the history has led to a wrong diagnosis of sarcoma, and the amputation of the limb. This was before the days of the Röngten rays and the immediate microscopic section of pieces of tissue removed at an exploration. A trivial injury as a cause should make us think of "Spontaneous Fracture" and carefully study the radiographic plate for signs of necrosis, caries, gumma, myeloma, cyst hydatid, chondroma, sarcoma or secondary carcinoma. The early stages of these conditions are easily over-looked. In the case of a young lady who very easily broke her radius some five years ago, the radiograph shows an early central growth at the site of fracture, but this was overlooked both by the radiographer and a very distinguished Scottish surgeon. Union was delayed, and yet no suspicion arose. Three years later a fracture followed another trifling injury and the radiogram showed an undoubted central growth which proved to be fibro-sarcoma. This was removed, and the 3 inch deficiency was filled by a graft consisting of the middle third of the fibula.

A boy of 18 very easily broke his femur, the radiogram was suspicious, exploration was declined. Union with excessive callus took place, refracture occurred later, followed by exploration. A mistaken diagnosis of fibro-cystic disease, later corrected to fibro sarcoma, was followed by amputation at the hip joint.

The late Mr. Targett, when shown a section from a mysterious central growth causing spontaneous fracture, found a columnar-celled carcinoma which he judged was secondary to a cancer in the rectum, and this view proved to be correct.

A boy of 11 had a large swelling with egg shell crackling in the upper part of the humerus with central absorption of bone, as shown by the radiograph; he was advised to have the right arm amputated for sarcoma, but the parents declined and brought the boy to me. Exploration showed a central cyst with a green stick fracture of the shell. The lining was scraped away, and the wound closed. The blood clot which filled the cavity on the removal of the tourniquet soon became replaced by bone, and the boy has a perfect arm four years later.

Treatment.

The ideal treatment should completely restore the use and shape of the broken bone, but this is not always possible. Restoration of function is more important than restoration of shape, but it is difficult to imagine perfect use without perfect shape. On the other hand the form of a bone may be regained, while the use

of the limb remains very imperfect from stiffness and weakness.

To attain our ideals it is generally necessary to

(1) Reduce the broken fragments into apposition or to "set the fracture."

(2) Retain the pieces in position until union has occurred.

(3) Maintain or restore the natural movements and power by exercise, passive movements and massage.

1. *Reduction.*—The public believe in "setting a fracture," and often complain that "it was not properly set at the time." They are right, and we should endeavour to set the fracture with the greatest care, and as soon as possible, before swelling from effusion of blood and inflammatory changes make the work much more difficult. For this an anæsthetic is invaluable in preventing pain and removing spasm, and thus enabling the setting to be done more deliberately and thoroughly.

Setting a fracture without the aid of an anæsthetic is often horribly painful for the patient, as I know from personal experience, and it is also very unpleasant for the humane surgeon who hates to hurt his patient and finds it difficult to complete his work satisfactorily. A bad result punishes both the patient and the surgeon.

While the muscles are thoroughly relaxed, and traction is maintained by the assistants, the surgeon angulates, rotates, and manipulates the fragments into position, if possible, with the direct or close guidance of the X-ray screen. Under these circumstances it is surprising how much can be done, but the best endeavours often fail to secure perfect reduction—some shortening from overlapping persisting. It is really important to remember, however, that the most serious and disabling deformities, augulation and rotation can be overcome in this way.

Restoration of alignment is more important than restoration of length, for without good alignment the muscles and joints have to work at a great and usually increasing disadvantage, while mere shortening can be compensated by a high heel in the case of the lower limb, and a little shortening of the upper limb is immaterial.

It must be admitted that it is often impossible to reduce a fracture perfectly without exposing it at an operation, and true wisdom consists in knowing when it is really necessary and reasonably safe to operate in order to obtain a good functional result.

(2) *Maintenance in apposition.*—Having reduced the fracture, the surgeon often finds it extremely difficult to keep the fragments in perfect position until they have united. What is the best way of doing this, by traction or splints or by operation? It is evident that it cannot be the same for all cases. A well applied plaster of Paris splint put on while the patient is under the anæsthetic is in my opinion the best conservative means of keeping a troublesome fracture in position, but it is of the greatest importance to watch and see that no splint is applied too tightly or allowed to become so (fig. 2).

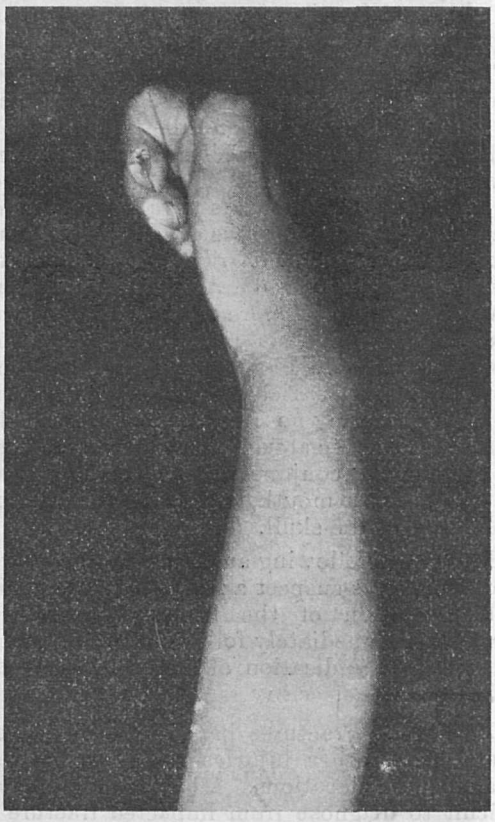

Fig. 2.—Volkmann's contracture following tight splinting. This deformity was corrected by shortening the radius and ulna, and the use of instruments.

An operation is by common consent the only satisfactory means of securing and maintaining apposition of such fractures as those of the patella and olecranon associated with separation

of the fragments, where a wire or screw well and aseptically inserted act perfectly and allow the early movements of the joints which are so essential for complete success.

On the other hand there are many fractures such as those of the upper two-thirds of the shaft of the fibula, for which an operation is unnecessary and wrong.

Most fractures of the shaft of the femur can be reduced and kept in position by traction, and it is clearly right to try this plan thoroughly in all cases, especially as operations for these fractures may be very formidable and even dangerous. An operation is rarely necessary for fractured femur in children.

Transverse fracture of the olecranon with some splintering (see Fig. 4).

Fractures of both bones of the leg often present such insuperable difficulties under conservative treatment that an operation becomes necessary to secure good function. One of the chief difficulties is in deciding which fractures are likely to do so badly under conservative treatment as to justify an early operation. Experience helps a great deal, and enables the surgeon to decide quickly and to operate in the most hopeful early period when complete reduction can be effected without having to shorten the bones, and while these are still firm and can be held by plates and screws, and the muscles have not had time to wither and shorten or the joints become stiff.

In many cases, however, it is difficult to decide before giving conservative measures a a good and fair trial, but there is no doubt that a delay of more than three weeks makes the operation more difficult and its results less perfect. As a rule a decision can and should be made within a week or nine days.

It would be very helpful if we could say definitely that certain fractures always need primary operation to ensure success; and perhaps further experience and comparison of

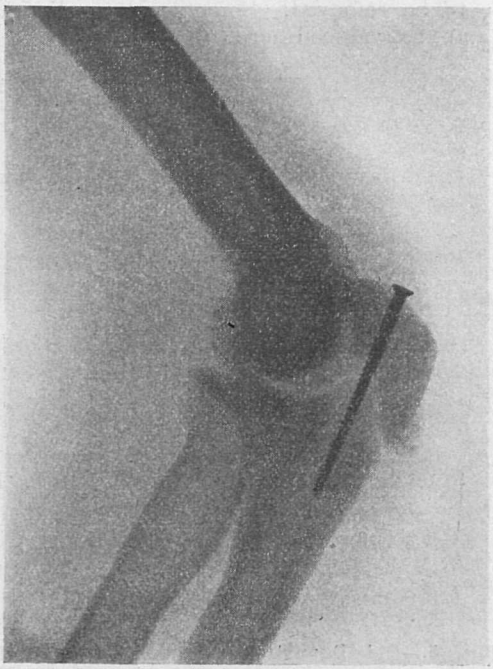

Fig. 4.—Fractured right Olecranon. The screw enabled this soldier to shave himself with the right hand a fortnight later, and the ultimate result was good, as usual.

results will enable us to do this. It may be wise to mention some fractures in addition to (1) transverse fractures of the patella and olecranon, which seem to me to require primary operation (see figs. 3 and 4).

(1) Fracture-dislocations of the ankle, such as Pott's and especially Dupuytren's, in an active or working individual, generally require an operation in order to obtain a permanently good result, for it is well known that conservative measures give a very high proportion of bad results with depreciation of earning capacity in these very troublesome fractures.

The radiograms shown on the epidiascope explain why this is so, for the tilted astragalus acts as a wedge, which gradually separates the malleoli and widens and disorganises the ankle joint. The other pictures show you how easy it is to prevent this by passing a screw through the external malleolus into the lower end of the tibia a little above the ankle joint. In my experience this has been a remarkably safe and successful operation, and the screw has never given any trouble or had to be removed. Some of the radiograms are reproduced here (figs. 5 to 8).

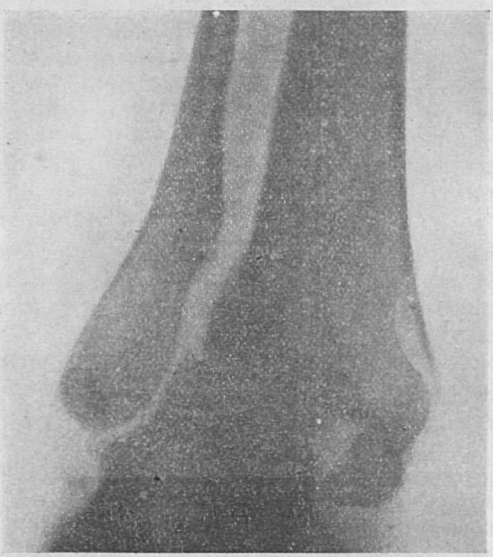

Fig. 5.—Old Dupuytren's fracture, a year after the injury when walking was very imperfect. Note the separation of the tibia and fibula and the tilting of the astragalus. This deformity and disability can be prevented by a screw as shown in Fig. 8.

(2) Fractures of the lower half of the shafts of the tibia and fibula are often extremely difficult to reduce or retain, for as regards the tibia they are usually oblique or spiral. Therefore an operation very often becomes necessary and should be advised as soon as it becomes clear that conservative measures are not succeeding. An operation under favourable circumstances gets these patients back to work much earlier and much more certainly than any other method.

(3) Fractures of both bones of the forearm, or a fracture of the ulna with dislocation of the head of the radius are very difficult to treat with splints, and often call for operation in order to avoid non-union or malunion with loss of rotatory power.

(4) Supra condylar fractures of the femur and humerus with displacement often need operation in order to preserve mobility.

(5) For similar reasons fractures of the scaphoid of the hand have to be treated by operation. Moreover, unless the loose bit of bone be removed, refracture is very likely, with recurrent pain and loss of function of the wrist—a matter of considerable importance in manual work and games such as tennis and polo.

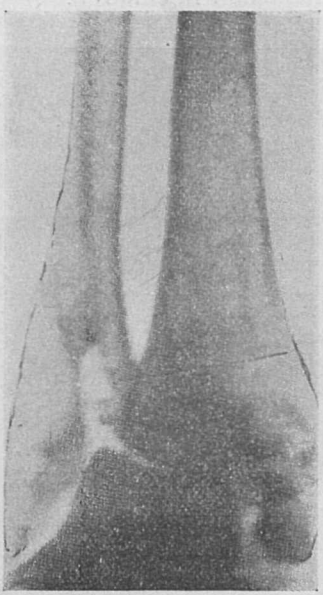

Fig. 6.—Another type of fracture-dislocation at the ankle. The man could not work two years later when the picture was taken. Note the wedge action of the astragalus.

It is clear that anyone who undertakes to operate upon a simple fracture takes upon himself a very considerable responsibility, for exposure of the fragments exposes the patient to the risk of infection, which if it takes place may have serious consequences. Moreover the surgeon must have considerable skill in the mechanical part of the work, otherwise the patient may lose instead of gain from an operation.

A compound fracture is rather different, for the risk of infection has already been incurred, but if the surgeon plates the fracture within the first few days he is adding to that risk, as

was so conclusively shown in the early days of the Great War when a few enthusiasts tried it rather indiscriminately with disastrous results. If the wound is dirty or likely to have been exposed to infection, it is clearly necessary to excise it like other contaminated wounds, but it is usually wise to defer plating until there is no fear of infection, otherwise the plating may fail in its object, cause necrosis, nonunion and spread of infection.

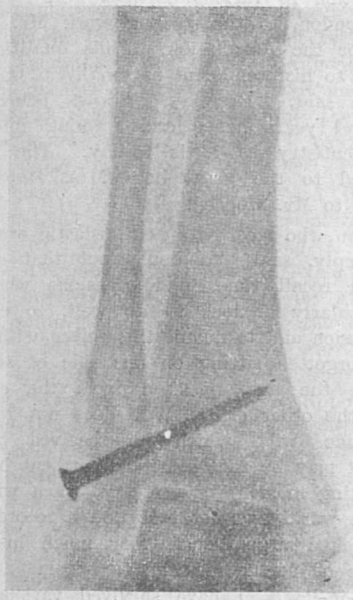

Fig. 7.—A similar fracture to that shown in Fig. 6. The patient walked well in six weeks. Note the effect of the screw, which does no harm. This has given no trouble in 10 years. Compare this with Fig. 8.

What is the best way of fixing the fragments in position at an operation? A long plate with screws is the most generally applicable and efficient. The plate must be long, and the screws must not be too near the line of fracture, where they may be sources of weakness, especially if the bone has been exposed to infection. In some fractures such as Dupuytren's, some oblique fractures, fractures of the olecranon, and of the neck of the femur and humerus, a simple long screw is most efficient and safe to use.

Wiring is sometimes very useful, especially in holding spiral fractures, and in fractures of the patella.

The experience of the infected wounds of the war made some surgeons believe that plating, wiring and screwing were dangerous and obsolete. Whereas in truth they are unsurpassed from a mechanical point of view, and, therefore, invaluable under aseptic conditions. Will anything hold a fracture of the femur as well as a long strong Lane plate?

Bone grafting or medullary pegging are comparatively inefficient mechanically, and in my opinion have not much scope in the treatment of recent fractures without loss of

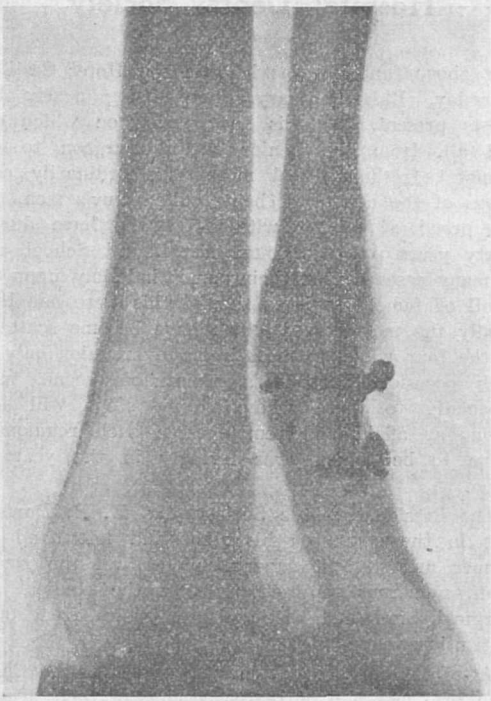

Fig. 8.—Note the inefficiency of a plate on the fibula, when the essential part of the fracture-dislocation—*i.e.* the separation of the tibia and fibula—is not treated as in Fig. 7.

substance, but when a considerable gap in a bone has to be bridged a well fitted autogenous bone graft is excellent and incomparable.

(3) *Maintenance of mobility and power.*—There is no time to say much on this important aspect to-day. Voluntary exercise is the most valuable and should be commenced as soon as possible, and the patient should be encouraged to do definite and systematic movements of the whole injured limb daily. Passive movements and massage are also useful, if carried out gently and intelligently, but violent passive movements do more harm than good, and are often very painful

It is better to give gas even repeatedly than to hurt the patient unnecessarily and cause resistive spasm, but the movements should be gradual and gentle even when the patient is anæsthetised for violent movements cause periostitis and arthritis and often do more harm than good.

22nd Annual Dinner of the Guy's Hospital Dental Society.

The above function was held in the Hotel Cecil on Saturday, 12th February, there being nearly 300 guests present. This is an occasion on which one and all, from the Senior Dental Surgeon to the youngest freshman, feel more than ordinarily conscious of the honour of being called Guy's men, and are proud of mixing with those who have during thirty years passed through the Dental School, and in many cases carved their names indelibly upon the scroll of fame. It is as though this were one huge family the members of which have become scattered to the four winds to meet in happy reunion only on such occasions. It is a remarkable scene, more especially to those whose future steps will lead them far afield and remote from such reunions, a scene to be talked over lovingly in the years to come.

The President of the Society, Mr. E. B. Dowsett, was in the chair, on his right and left hand the former and present superintendents, all the Dental Staff, numerous representatives of the Medical and Surgical Staff and distinguished guests from other institutions.

After the loyal toasts had been drunk, the Chairman read messages of regret because of their absence from Viscount Goschen, Dr. French, Sir Alfred Fripp, Mr. Newland-Pedley, and Mr. Wynn Rouw. The toast of Guy's Hospital and Schools" was then proposed by Professor Wright, Dean of the London Hospital, in a speech which must have been as music in the ears of all Guy's men praising as it did our venerable institution, what it stands for and the men it has produced.

The Superintendent of Guy's, Mr. H. L. Eason, then suitably replied, dwelling at some length on the desire of the authorities to preserve this as a voluntary institution; he drew attention to the words of our great Founder in which he laid it down that the patients were to receive free treatment.

Mr. F. J. Pearce then, on behalf of the past and present members of Guy's Hospital Dental School, presented two portraits of Mr. M. F. Hopson, one to the British Dental Association and one to Mr. Hopson himself. Mr. Pearce only voiced what every one feels with regard to "the Grand Old Man" of Guy's and his remarks upon the veneration and esteem in which Mr. Hopson is held were greeted with a remarkable and memorable outburst of enthusiasm. Surely never was a man toasted with greater spontaneity and sincerity than was Mr. Hopson on this occasion.

Mr. Norman Bennett, on behalf of the British Dental Association, in a happy speech, full of wit and with many humorous references to their friendship, accepted the portrait. He referred to their long association in various capacities in the dental world in London, to the sterling work Mr. Hopson has done for the Association, to his qualities as a teacher and to his wonderful personality. One could imagine, he said, "Hoppie's" fillings being found two thousand years hence and forming interesting relics of dentistry as it is to-day. The speaker also referred to the great help Mrs. Hopson has always been to Mr. Hopson.

Mr. Hopson, who received an enthusiastic ovation on rising to reply, said: "I doubt not that everyone present can recall times and occasions when they were particularly anxious to do well, to create a good impression and to acquit themselves with credit. Who has forgotten sitting on one side of the table waiting for the first question from the examiner sitting on the other side? Who does not remember the solicitude with which he received his first patient? It may be that some one present has more than a fleeting memory of the day, when without a bean in the world and not too good a record behind him, he visited a gentleman very much his senior, in the hope of persuading him to become a benevolent father-in-law. I have survived various trying experiences of that sort, but on looking back upon them, they appear trivial compared with the position in which I find myself at the present moment. How can I hope to convert into mere words the feelings of gratitude which your great kindness has evoked? It would be easier could I but persuade myself that I were in some measure worthy of the very nice things which have been said about me and in some degree deserving of that which you have done. As it is, I feel as if I must somehow or other, unwittingly, believe me, have deceived you as to my true character. ('No.') I often think, Sir, how nearly I missed all the good things which seem to have just tumbled into my lap since I came to Guy's, for it was by the merest accident that my steps were turned in that direction. I had finished my three years' pupilage with a practitioner in the country, and was looking round for a hospital and school at which to complete the required curriculum. I had already interviewed two Deans when I met an old Guy's man, who practised in the little town in which I lived, and he told me that he had just heard that they were thinking of starting a Dental School

at Guy's. He urged me to make some inquiries. So, one morning early in January, 1889, I crossed London Bridge and entering St. Thomas's Street, inhaled for the first time in my life that atmosphere we all know so well as being peculiar to that locality. That morning it struck me as being a blend derived from decaying vegetable matter, hops, human nature, and iodoform. (Loud laughter.) Passing through the main gates, I paused to look at Scheemaker's statue of our pious founder; there was a garland round his neck, a pewter pot and the remains of a guttered candle on top of his head—emblems I afterwards learned of the newness of the year. At the lodge I was received by Parsons, the porter, whom I always liked as a genial soul, and with the greatest courtesy he showed me the way to the Medical School Office adjoining the Dispensary. Just as I was about to enter, I caught sight of another figure in uniform. At first I thought he was a guard on the South Eastern Railway, and then I noticed that he wore a medal on his breast and his legs were bowed; making a prompt and accurate diagnosis, which did not exclude the possibility of favours to come, he met my glance with a Service salute; that was Hession, the old Commissionaire. Inside the office there were Mr. Wells, Morley (the incorruptible janitor), and in a junior capacity, Mr. Croucher. But my appointment was with the Dean, and I was very soon in the presence of Dr. Cooper Perry. He told me that the Governors had approved the scheme for the foundation of a Dental School, but that the staff had not yet been appointed; there were little details to be worked out, and it could not possibly be opened before May. 'But,' the Dean added, 'There is no reason why you should not join up at once, and you can get on with anatomy and physiology, and dissect a part before the end of this Session.' Then some beneficent spirit whispered in my ear—I have not consulted Sir A. Conan Doyle or Sir Oliver Lodge, but I am quite sure in my own mind it was the voice of a little lady urging me to accept Sir Cooper Perry's good advice. To curtail my story, I expressed my readiness to join up straight away. There was one little difficulty, however, to be overcome. When we came to the question of fees, I was informed that it had not yet been decided what sum dental students should pay, but eventually, in return for a cheque, I received a card entitling me to become a perpetual student. For rather more than thirty-two years, the Medical School office has kept its part of the contract, and I have not been turned out yet, and as for my share therein, I trust I may be regarded as a learner still. Seeing the wonderful progress the Dental School has made, the reputation it has already won, and the traditions it is slowly but surely building up, it may perhaps be pardoned to me if sometimes I am tempted to stand upon my toes and pride myself upon having been the first, and for several months, its only student. But when I recall the great and illustrious men who have been connected with Guy's during the 200 years of its existence—men such as those to whom Mr. Pearce referred the other day in his presidential address before the Metropolitan Branch of the British Dental Association; when I think of those to whose prescience the foundation of the school was due, notably Mr. Newland-Pedley (whose absence we all regret, and from whom I received yesterday the kindest of letters, very characteristic of 'F.N.P.'); when one thinks of our first Dean, Sir Cooper Perry, who devoted his rare and keen intelligence and his great administrative faculties to promoting the success of the school; when I remember my old teachers, my past and present colleagues, and to go further afield, those not of Guy's, but with whom solely through my position at Guy's, I have been brought into intimate connection—Mr. Norman Bennett and Mr. W. H. Dolamore, ever ready to sacrifice their personal interests to those of their profession; when I remember these things I am brought to my knees by the knowledge of the poor claims that are mine to bear them company.

Do you wonder that, next to my own family, there is nothing dearer to me than Guy's and my long association therewith? To it I owe more than I can express, far more than I can hope ever to repay. It has given me whatever measure of professional success I may have achieved, either in a public or in a private capacity. The experience afforded in working there has, I believe, enabled me to take a wider, broader, and I trust a more charitable view of the world, of men, and of affairs, and, above all, it has given me that which Stevenson said are the true end and the rewards of life—a host of friends, frank, honest, generous, affectionate, and ever-loyal friends; many of them are here, but there are others scattered all over the globe. And now to-night it has culminated in this delightful and endearing manifestation of their regard. It is indeed a great and a good thing to be a son of Guy's, and to dwell in the hearts of her people. One of the last little secret yet innocent vanities a man surrenders is the desire not to be forgotten when he is gone. You by your kindness, and Mr. Frank Salisbury by his great and wonderful art, have assured to me the sweets of remembrance. No matter how poor I may die, the world will know that I lived rich in the love of my friends—I shall never forget."

Other toasts were "The Visitors," by Mr. H. C. Malleson who expressed pleasure at the presence of so many distinguished men, not of Guy's, and bade them a hearty welcome, Mr. A. E. Ball, President of the B.D.A. replying suitably. "The Chairman," by Mr. Coysh, Secretary of the Guy's Hospital Dental Society, and the final summing up by the

Chairman, Mr. E. B. Dowsett, who, amongst other things, drew attention to the value of the Society to students, and to the praise due to Mr. Coysh for his hard work and energy in the tremendous task of organising the dinner.

Mr. Coysh is to be congratulated on the splendid way in which the function was organised and carried out, and the fact that he had spared no pains to ensure its success which was for the most part due to his efforts.

During the evening musical items were rendered by several artists and the proceedings ended at about 11 p.m.

Special Constabulary.

Guy's Unit.

LIKE other Hospitals a permanent unit has now been formed, and Mr. Lane-Roberts, F.R.C.S. has been appointed to take charge as Chief Inspector. Over 160 students have enrolled for duty and this number is still increasing. The Unit, officered by 2 Inspectors and 3 Sub-Inspectors, is divided into two Companies, which have been sub-divided into squads of 10 under a Sergeant. Students desirous of enrolling should forward their names to the Chief Inspector, or Inspectors Housden and Rowbotham.

Eight officers and 36 men formed a detachment sent from this Unit for the Special Constabulary Parade which was inspected by H.R.H. Prince of Wales, at the Olympia, on February 1st. Those who turned out are to be heartily congratulated upon their smart appearance, which in every way reflected great credit on all concerned.

STORING OF UNIFORMS.

Store Room.—A room adjoining the Works Department has been placed at the disposal of the Unit for the purpose of storing uniforms and equipment. Pegs have been allocated to each member of the unit and it is requested that members will strictly adhere to the pegs allocated.

Parade.—All members of the Unit are requested to parade outside the Dental School as under, and bring their overcoats, uniforms and caps.

"A" Co., Thursday, March 10th at 1 p.m.

"B" Co., Friday, March 11th, at 1 p.m.

Equipment.—Armlets, truncheons and whistles will be issued to those who have not already received them.

C. S. LANE-ROBERTS.
Chief Inspector.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

John Keats.

SIR,—It was with much pleasure I read in your "Passim" in the last GAZETTE a reference to a proposed Memorial to that wonderful poet Keats, whose centenary will be celebrated this year. In vain I have looked about the Hospital for some reference to him, his work, or the fact that he was at one time a student at Guy's; scarcely anyone here seems aware of the fact at all, or if so they do not care.

Only recently I was showing a friend round the Hospital, and in telling him of the celebrated men who had one time or another dwelt within these old walls, I also mentioned Keats. My friend promptly asked me whether there was not some memorial tablet or record of some kind of this fact, and I was ashamed to confess I knew of none.

Sir, we call ourselves men of science, but to be men of science we must have culture, must know something of literature and art and the men and women who have left their mark upon this earth. I fear most of us do not even attempt to develop that side at all; one is almost ashamed to confess that one reads the poets. Moreover, little interest appears to be taken in the History of Guy's, for there at least there is mention of Keats' studentship at this Hospital.

I should like to most heartily endorse your remarks on the desirability of erecting some inexpensive but satisfactory tablet in a conspicuous place in the Hospital. I for one should be only too glad to contribute to such a cause, and I feel certain many others will be found who will feel the same about this matter.

Let us honour and commemorate the great men who have been Guy's men, and in doing so let us not forget him whose song is so beautiful: John Keats, one of England's greatest lyric poets.—I am, Sir, Yours, etc.,

M.B.

P.S.—Might I suggest that about the time of the Centenary celebrations, a short article on the life and work of the poet and his connection with Guy's should appear in the GAZETTE?

Guy's Hospital, S.E. 1.
22nd February, 1921.

The Heart in Muscular Exercise.

SIR,—I hope I shall not trespass unduly upon your valuable space in asking you to permit me to make a few observations on the subject of Mr. Currie's most interesting paper in your issue of February 5th.

JOHN KEATS.

The physiological and pathological aspects of athletics and training have greatly interested me for many years, and I have enjoyed, perhaps, exceptional opportunities for experiments and observations thereon. (I have not the honour of claiming Guy's as my alma mater, but since I edited the Journal of a sister hospital some ten years ago, when I regularly perused the contemporary periodicals of my colleagues, I have preserved an affectionate acquaintanceship with the "Guy's Hospital Gazette.")

On the more academic side of Mr. Currie's treatise, particularly relating to the mechanism of cardiac contraction, I do not wish to dwell, principally because I believe that far too much attention has always been paid to the heart itself in the problem of severe exertion. As Mr. Currie says, the nutrition of the heart muscle is a very important factor; but from the mechanical standpoint it is remarkable how compensation can be maintained provided the muscle itself is healthy. It is a matter of common knowledge that the most severe physical exertion is quite compatible with the existence of a valvular lesion, and I myself have seen first-class athletes with well-marked V.D.H., and even in one instance with aortic regurgitation and the classic big left ventricle.

What, however, is generally overlooked is the circumstance that the heart is just one of the elements to be considered. What makes one man a fine athlete and another a duffer? Not merely the possession of a sound heart, a full percentage of hæmoglobin, good respiratory capacity and proper muscular development: but all must be co-ordinated with a suitable skin, and above all an appropriate nervous system with which is particularly connoted a well-balanced vaso-motor centre.

And, possibly, too, something even more elusive than these. I think the day will come when the problem will be explained not by the anatomist nor the physiologist, but by the bio-chemist. So that I cannot whole-heartedly agree with Mr. Currie's idea of training "developing a powerful heart and strengthening the circulatory system." True, Mr. Currie, adds that the nerves as well as the muscles are trained, but his emphasis upon the circulatory system leads him to say that the trained man "can with his powerful heart attain to the required output without the same need for acceleration of the pulse as is felt by a sedentary person." But is this so? Certainly not in my experience, for the pulse rate during severe exertion is in a perfectly trained man as frequent as that ever attained by a man completely out of condition. *But the rate in the trained man very rapidly falls to normal.*

A great deal of work has been done on this subject of pulse rate, and by physiologists at Guy's *par excellence*. But I venture to refer to some observations of my own which were carried on over a very long period and which I hope soon to publish. As one expected, the increased frequency of pulse rate bore some relation to the severity of the exercise, but not exactly in the way I anticipated. If the relation to severity were constant we should expect to find the biggest effort in those feats which are from the subjective standpoint the most severe. Now any experienced athlete will agree that it is a far greater ordeal and one liable to be accompanied by greater prostration for a trained man to run a quarter mile "all out" than say five miles at a comfortable pace. Yet I have found that no matter the severity of the comparatively short effort, the deceleration of the pulse rate was rapid, whereas no matter the moderation of the longer effort the deceleration was proportionately protracted. In other words the duration of the increased frequency depended upon the *duration* of the exercise. I would like the Guy's physiologists to decide if this observation throws any light upon the causation of increased frequency; to my mind it supports the theory that loss of vagal tone is responsible.

I had hoped that from such physiological observations something might be gained towards the elucidation of that bewildering condition familiarised by the convenient but exceedingly unscientific term, "D.A.H." Lewis has, of course, emphasised the inaccuracy of this expression and his authority has given the cachet to the belief that many of us always entertained that the heart itself is structurally quite sound. The pride of a parent (or at least one of seven parents) must be my excuse for referring to the somewhat cumbersome title of "neuro-circulatory asthenia," which was evolved at Colchester as a substitute for "the effort syndrome." Mr. Currie says that the subject of this condition bears the same relation to the untrained healthy man as the latter does to the trained athlete. Not quite, I think. I should say he is more nearly equivalent to the healthy man (trained or untrained) temporarily suffering from a toxæmia and that his vaso-motor system has been knocked off its balance for a greater or shorter length of time (perhaps for the rest of his life) by a toxin or some psychic disturbance or probably by both in concert. But as Mr. Currie himself says, we are here on difficult ground: for indeed a number of very different conditions have all been lumped together and considered as one and the same thing.

I should have liked to debate also one or two highly interesting controversial points such as the phenomenon of second wind, the influence of diet upon training and the effect of tobacco upon athletic efficiency, but already I feel I have long since exhausted your patience and toleration. So I will content myself in conclusion by expressing my very keen appreciation of a most admirable paper, the delivery of which I should have greatly enjoyed, and by venturing to modify one very important statement of

Mr. Currie's. He says, "The evidence that athletes are subject to heart strain and die early is very small." I would like to substitute for "very small," "non-existent."—I am, Sir, Yours very truly,

ADOLPHE ABRAHAMS.

24, Park Crescent, Portland Place, W. 1.
19th February, 1921.

Lectures on General Practice.

Dear Sir,—Surely many reflective medical students must have asked themselves why the curriculum at Guy's does not include instruction in the business and social aspects of General Practice—including medical etiquette.

"Before the war" I am told that lectures by General Practitioners on such subjects were of no infrequent occurrence, and it seems that their reintroduction would be much appreciated. Should such a course be contemplated it is to be hoped that those in authority will: (1) Arrange suitable times and days—not cup-tie days for example. (2) Advertise them at least a week beforehand.—Yours faithfully,

"AUTOLYCUS."

The College, Guy's Hospital,
London, S.E. 1.
March 1st, 1921.

British Chemical Manufactures.

Dear Sir,—We, the undersigned, makers of fine chemicals, extended our research and manufacturing plant at the urgent appeal of the State during the tremendous years that followed 1914, in order to secure those essential products of Science without which victory could not be attained. The full record of wartime achievements in the sphere of fine chemicals would read like a romance were the full history disclosed.

This key industry is now endangered, and unemployment is rife in it, owing to the flood of imports from abroad which, among other circumstances, the present condition of the Exchanges makes devastatingly possible.

We desire to submit to public knowledge the following facts:—

1. The application of chemical science to industry is a necessary factor for the preservation of our world position in commerce. It is also true to say not only that the chemist and the laboratory are in the first line of national defence, but are pivotal in the development of our industrial and commercial resources and wealth.

2. At very considerable cost, essential plant was erected during the war years, and all of it can now be put to peaceful purposes for the continuance in this country of a Fine Chemical Industry not inferior to Germany's. But, under the present unfair economic circumstances, this plant must become idle and useless unless the State takes measures for its safeguarding.

3. The Fine Chemical Industry, mobilised and expanded in the the hour of the nation's needs, provided during the war—to give a few examples—(a) essential medicinal preparations for naval, military, and civilian hospitals; (b) the higher forms of explosives and gases; (c) photographic chemicals for aerial use; (d) research chemicals, without which the development of many new industrial processes would have been impossible.

4. British science is no whit inferior to that of competing nations, nor are British Chemical Manufactures inferior in quality.

We feel it is our bounden public duty to make known to the country the national importance of an industry which is indeed a key to the unlocking of many doors of economic wealth in the future.—Yours faithfully,

Stafford Allen & Sons, Ltd.
A. Boake, Roberts & Co., Ltd.
Boots Pure Drug Co., Ltd.
The British Cellulose & Chemical Mfg. Co., Ld.
The British Cyanides Co., Ltd.
The British Drug Houses, Ltd.
British Vegetable Products, Ltd.
Burroughs, Wellcome & Co.
W. J. Bush & Co., Ltd.
J. M. Collett & Co., Ltd.
Evans, Sons, Lescher & Webb, Ltd.
Grays Dyes & Chemical Works.
Hopkin & Williams, Ltd.
Howards & Sons, Ltd.
Johnson & Sons, Manufacturing Chemists, Ltd.
London Chemical Works, Ltd.
May & Baker, Ltd.
Thomas Morson & Son, Ltd.
Pierson, Morrell & Co., Ltd.

19th February, 1921.

Change of Address.

Robert Cuff, 14, Avenue Victoria, Scarborough.

Major K. Black, F.R.C.S.Eng., 23, Magdalen Road, Wandsworth Common, S.W. 18; after March 6th c/o The Principal Medical Officer, Singapore, Straits Settlements.

Interesting Cases in the Medical Wards

Cases under Dr. Fawcett and Dr. Ryle—
Esther 34. Myeloid leukæmia.
Stephen 47. Hodgkin's disease.
42. For diagnosis.

John Keats Centenary.

WE reprint on the occasion of the centenary of the death of John Keats the following article which was one of a series of "Tales of Old Guy's," published in the GAZETTE in 1905.

"Junkets,"

It is possible that to the majority of Guy's men the name that heads this article conveys no meaning, excepting in its culinary interpretation, and recalls no reminiscences. If that be the case, the fact is in itself sufficient apology for this article, which has for its object the brief sketching of the history, so far as Guy's is concerned, of one whose association with out hospital must be regarded as an added title to fame for this institution. If, on the contrary, such be not the case, if the present-day Guy's man, who lives in an age when encyclopædic knowledge can be acquired in sixpenny monthly doses, knows the history of British literature so well that the name Junkets recalls to his mind the personality and the life of one who, in the words of a literary critic, "had he lived and realised the promise of his younger years, would have been the greatest of English poets," then, indeed, my apology must be the want of collated particulars about Keat's medical life and his terms at Guy's.

For this is a tale of John Keats, poet, playwriter and apothecary, the Æsculapian singer, as Dr. Richardson called him, the "Tiny Keats" of his fellow dressers at Guy's, "my Adonais" of Shelley, and the "Junkets"—from the contraction of the initial letters of his name—of his friends Leigh Hunt and Henry Stephens. And it is a tale which concerns only his medical life, which keeps no touch with the period after 1818 or the years antecedent to 1814. With that part of the story I shall presuppose familiarity on the part of the reader, if not intimate acquaintance with the details of the poet's life, then at least sufficient to recollect the main incidents, such as, for instance, that Keats was born, the son of a stable keeper, in October of the year 1795—the exact date being still a matter of controversy, though most authorities incline to fix it as being the 29th October; that he was a seven months' child, with what our ward clerks might call "a constitutional tendency towards consumption" in his family, and that at the time of his mother's death he was left in possession of a legacy of some £2,000, and under the care of an excellent guardian, a Mr. Abbey.

Medically considered, the history of Keats begins with his indenture to an Edmonton surgeon "of good repute," with whom he stayed a couple of years. We know that at that time he had already formed an acquaintance with Cowden Clarke, to whom he owed his introduction to the Elizabethan poets and afterwards to the literary set in London, where he met Haydon, Shelley, and Hunt. There is little to be gathered about his life at Edmonton, except what Clarke, in his interesting article in the "Gentleman's Magazine," has left on record. We know, however, that his articles—for which he had paid £210—were cancelled by mutual consent. Students still speculate as to the precise circumstances which led to this cancellation, and Forman has attempted to find, in the phrase "It was not this same hand that clenched itself against Matthews,"—an expression which occurs in one of the poet's letters to Reynolds,—a justification for the statement that surgeon Matthews and his young apprentice parted in anger. In those days the life of a doctor's apprentice was not a bed of roses, and it is highly probable that Keats, sensitive and impulsive as he was, regarded his apprenticeship in an unkindly light. The literary student will at once think of George Crabbe, who was also bound apprentice to a surgeon in his boyhood, and in that capacity was forced to sleep in a barn and run errands for his master, from whom it appears he learned little medicine and less anatomy. Dr. Richardson, in the often-quoted article in that mine of medical lore, the old "Asclepiad," indeed assumes that it was that period of apprenticeship which gave Keats his distaste for medicine and for the profession, and speculates in an enthusiastic, though somewhat unwarranted, fashion on the possibilities which might have resulted had surgeon Matthews treated his pupil with greater care.

After leaving Edmonton, Keats stayed with his friend Clarke for some time, reading Browne and Burton (drawing from the latter the ideas for "Lamia" and "La Belle Dame sans Merci") and finally came up to London. He wrote regularly to Clarke, and his first letter, undated, is a mere note to tell his friend his address. "Although the Borough is a beastly place in dirt, turnings and windings, yet No. 8, Dean Street, is not difficult to find," he writes. There at No. 8 he lived for some six months, entering at Guy's as a surgical pupil. In his second term at Guy's he was introduced (it appears by Sir Astley Cooper) to two senior students, one of whom was George Cooper, afterwards demonstrator of anatomy at St. Thomas's, with whom he went to share rooms in St. Thomas's Street, at the house of a tallow chandler named Markham. When his companions left the hospital, a few months later, he shared rooms in the same house with two students of his own year, George Wilson Mackereth and Henry Stephens. The latter has left some interesting reminiscences of that time. Himself a poet, Stephens was at the time engaged in writing a tragedy, and he must have found Keats a congenial companion.

He remarks that "Little Keats" was fairly popular, but was often teased on his pride, his poetry, and even on his birth. It seems that the three friends spent several evenings in literary readings, at which they were joined by two students from Barts. At these they discussed literary matters, and Stephens has noted that they paid great attention to Keats' opinions, which were generally diametrically opposed to theirs. Here, too, the poet's brothers frequently visited him, and were highly indignant that his fellow students should make fun of him, since they regarded his poetry as the first flights of genius. In the summer of 1816 Stephens left, and Keats went to live with his brothers in Poultry in a passage leading to the Queen's Head Tavern, a residence which, in the following year, he changed for lodgings at 76, Cheapside.

It is this period, 1814—17, that particularly concerns us, and unfortunately the accounts which we have of him during that time are meagre in the extreme. We can, however, make up the deficiency with what we know from other indirect sources, and these tell us much that is of interest. We know that he attended Mr. Green's anatomy lectures diligently, for he kept a note-book (now in the possession of Sir Charles Dilke) of which one of his biographers has given an interesting account. "I have before me," says Mr. Colvin, in the concise little life of the poet in Mr. Morley's "Great Writers" series, "the M.S. book in which he took down his own notes of a course, or at least the beginning of a course, of lectures on anatomy, and they are not those of a lax and inaccurate student. The only signs of a wandering mind occur on the margins of one or two pages, in the shape of flowers (rather prettily touched), but the notes themselves are both full and close so far as they go. Poetry had, indeed, become Keats' chief interest, but it is clear at the same time that he attended the hospital and did his work regularly, acquiring a fairly solid knowledge, both theoretical and practical, of the rudiments of surgical and medical sciences, and he was always able to speak of such subjects with a certain amount of mastery." Keats himself, writing to his friend Clarke, tells us how little he relished these lectures at times. "The other day, during the lecture, there came a sunbeam into the room, and with it a whole troop of creatures floating in the ray, and I was off with them to Oberon and fairy land." It is a mind wandering, with which first year men will heartily sympathise, and sympathy will be more general when one takes into consideration how different anatomy lectures were in those days. Each lecture occupied an hour and a half, during which time Mr. Green contrived to "run through" all the bones, "referring to a red pocket-book when he was at a loss," as a contemporary says, and at the end of which another demonstrator took up the "muscles of the face" and rapidly discoursed on their relations and attachments. There was a large amount of tedious repetition, the lecturer repeating each statement thrice—a custom which must have interfered seriously with the originality of his remarks and the attention of his class. We have no certain knowledge of Keats' dissections, but it is probable that he did a fair amount of work in the dead-house, for we learn from the minute book of the Society of Apothecaries that he was admitted after passing his examination on the 26th of July, 1816, and we know, from various sources, that he passed with credit. That in itself does not prove that he knew much. South, who came to Guy's a few years afterwards, has left on record an account of the examination in those days, and from it one can easily see that the standard was not high. At that time there were three examiners, Brande, who examined Keats, George Johnson of Guy's, and Tommy Wheeler, also of this Hospital. Johnson was the secretary of the now defunct "Physical Society,"* "a little vulgar person of blunt manners, not refined in his use of words, and having an inveterate habit of making the letter v supply the place of w, and vice versa." It does not appear that he knew much anatomy himself. After his appointment he came to attend Green's classes, sitting alongside the students he had to examine to brush up his anatomy, and there is a story that in a viva voce he requested a candidate to point out the lobulus Spigelii *of the lung*. Wheeler, the other examiner, was a keen botanist who counselled every candidate, as a preliminary to examination, to learn botany and read a chapter of the Greek testament. South himself was examined by Sir William Blizzard and Sir Everard Home, and his account of his viva throws an interesting sidelight on the manners of examiners in those days. "'Well, sir,' said Sir William, 'what are the regions of the abdomen?' I puzzled and puzzled in vain, and finished by replying, 'I did not know, I had never heard of them.' 'Oh yes, you must,' said Sir William, but I insisted, and said they were not taught at our school. This he would not assent to, and pressed me angrily, when Sir Everard broke in with, 'Pooh, pooh, Sir William, what's the good of asking such foolish questions? They don't teach these things nowadays.'"

It is perhaps interesting to note here the books that Keats was supposed to read, and no doubt diligently perused, in his hospital days. Writing to his friend Teignmouth, in 1818, he refers to them. "Were I to study physic, or rather medicine, again, I feel it would not make the least difference in my poetry; when the mind is in its infancy a bias is in reality a bias, but when we have acquired more

*Its place has been taken by the Pupil's Physical Society.

strength, a bias becomes no bias. Every department of knowledge we see excellent and calculated to a great whole. I am so convinced of this that I am glad at not having given away my medical books, which I shall look over again to keep alive the little I know thitherwards." An interesting passage, showing as it does that he had taken a broader view of life, and that he still felt a regard for his old studies. Probably amongst the books he mentioned—he gives no names—were those most in vogue at Guy's then. There was the "London Dissector," the contemporary Cunningham; Fyfes' "Anatomy," in three octavo volumes; Innes "On Muscles;" Barclay "On Arteries," and Saunders "On the Practice of Physic." Of the larger works there was Cheselden's magnificent "Osteographie," with its beautiful plates, hardly, however, a student's book—and Clarke's "On Diseases of Children."

On the 3rd of March, 1816, Keats was appointed dresser to Mr. Lucas, son of Billy Lucas, of whom we have a vivid contemporary pen picture, in which he is described as "a tall, ungainly awkward man, with stooping shoulders and a shuffling walk, as deaf as a post, not overburdened with brains of any kind, but very good-natured and easy and liked by everyone." At that time "Calomel" Curry and Alexander Marcet were full physicians at the hospital, James Cholmeley and James Laird being assistants, while the aged Dr. Blundell was obstetrician. Aston Key and Callaway were already on the staff, and Bell, the comparative anatomist was thinking of his Zoological Journal soon to be started. Amongst Keats' contemporaries one may mention Bright, who was a fellow student (Addison came two years later), Bill Crouch, the resurrectionist, and the official "bug catcher" at £40 a year. It is easy to picture in one's mind the hospital as it was in those old days. Joseph Warner's letter to Gunning and John Howard's report of his visit, and above all the detailed account of South, give us much instructive information. Cornelius ward was there then, and the statue in the front quadrangle, the gates at the entrance and the side wings. The pupils were classed as apprentices and dressers, the rule being that each surgeon had four followers, of which two at least had to be dressers. A certificate was required from each pupil, signed by his former master, to vouch for the sobriety and moral conduct of the pupil. It would be interesting to find if Keats' original certificate still exists, and if so whether Matthews signed it. Each dresser paid £50 per annum, the money being pooled and divided between the surgeons and, for some mysterious reason, the apothecary, though from all accounts the latter functionary never gave the students the least assistance. There was one "take-in dresser," who was lodged and boarded at his own expense and had the right of getting a friend to assist him. "After the weekly 'take-in,'" says South, "the surgeon who took in waited till his patients were warded and then went round to prescribe for them. No history of the case was taken, but the diet was marked on the ticket. All orders were given verbally to the dresser or ward sister. The more industrious dressers kept notes of their own cases, but such were not usually required. The physician, however, acted differently. Each case having been examined, the physician dictated the history and symptoms to the dressers in Latin—sometimes not very first-class," as it is related of a choleric member of the staff who bawled out "Faber Londinensis" as the equivalent for every Borough occupation. "The clinical remarks were few, and we generally dreaded asking questions for fear of being snubbed. Each surgeon and his colleague physician went round twice a week, the former at twelve, the latter at one o'clock. The physicians were more punctual than the surgeons, whose pupils, according to their liking of the surgeon of the day, awaited his arrival in the square, some in quiet conversation and not a few in horse-play—which, for no special reason I can make out, has appeared to me, after fifty years' observation, to be a material condition of surgical pupilage. On the surgeon's arrival the fun ceased. He was immediately attended by his dressers, whose dignity was indicated by each carrying a tin *plaister box, in shape not unlike a knife box.*" We learn from the same account that the surgeons provided their own instruments, and usually did the first few dressings after an operation; that the only medicines used on the surgical side were calomel, Dover's powder, and castor oil; and that the surgeon and most of his attendant pupils went round the wards with their hats on. The nucleus of a museum had been started at that time, though no official curator had been appointed and no catalogue was in existence. The specimens do not seem to have been much used by the students, who were, however, assiduous in their attendances at operations and post-mortems.

In this atmosphere John Keats lived for the greater part of a year. We have contemporary accounts of his appearance at that time, and although they vary as to particular details they are yet fairly in unison in the main. A wonderfully mild face, with large grey-brown eyes, a rather pale complexion and a wide mouth, a face which in profile showed clearly-chiselled lines and marked regularity of features. The etching prefixed to the "Letters to Fanny" is probably the best representation of him at that period, although his friend Clarke preferred the larger portrait executed a few months later. He dressed shabbily, carelessly, disregarding appearances as he did opinions, and possessed an amount of moral and physical courage which must have stood him in good stead—a sort of "terrier courage" Stephens calls it. At the same time there is evidence of his exceeding mildness of disposition, a mildness that amounted almost to shyness, especially, as he himself says, in surgical work

that required initiative. Writing to Browne he says, "My last operation was the opening of a man's temporal artery. I did it with the utmost nicety, but reflecting on what passed through my mind at the time, my dexterity seemed a miracle, and I never took up the lancet again." When we remember that Astley Cooper broke down when he had to operate on a friend's child, that Larrey wept when he saw his orderly on the operating table, and that South tells us that it took months before he could accustom himself to hear a child cry under the knife "without getting sick at the sound and having to leave the theatre," when we remember that those were the pre-chloroform days and that the operator required a far greater degree of medical courage than he does to-day, we can sympathise with Keats as much as we sympathise with his mind wandering during Mr. Green's anatomy lectures.

While at Guy's, Keats wrote and composed several of his shorter pieces, all of them giving promise of his marvellous development that was to come during the few years immediately preceding his death. That wonderful line—

"Silent upon a peak of Darien,"

was written before he came to the Hospital, while the exquisitely finished ballad—

"Oh what can ail thee, knight at arms,
Alone and palely loitering?"

is perhaps the only one of his better known poems that was certainly finished in his hospital days. It is useless, however, to discuss the relative date of his works. Such a discussion, interesting enough to Keats' students, is controversial in character and not much to the point so far as we are at present concerned. He read much, confining his reading chiefly to Elizabethan authors, and glancing besides at classical writers such as Juvenal, Lucretius and his favourite Virgil. Greek he did not master fully, and he never seems to have been able to read a Greek author with any degree of comfort.

With the latter end of 1817, Keats finally left the hospital, betaking himself to his friend Clarke, with whom he spent a couple of months. He then started on a long walking tour, rendered necessary, perhaps, by his weak state of health consequent on his devoted nursing of his brother Tom who was dying of consumption. Of this tour we have several accounts. We know, for instance, that he went out of his way to call on his old Guy's chum, Henry Stephens, at that time a prosperous country practitioner who had given up play-writing to experiment on the therapeutic use of creosote. To Stephens he confided his determination to quit the medical profession and devote himself definitely to literature. And with this confession we may consider his medical history closed. It is true on three occasions, at various later dates, he refers to his profession, once when he announces his intention—presumably in a joking fashion—to accept a post as surgeon on board an Indiaman, and on two other occasions when he talks bitterly of his literary prospects and solaces himself with the thought that his gallipots—to which, by the way, the Edinburgh reviewers were strongly advising him to return—might still yield him a livelihood. Taking all these references into consideration, I think one is forced to the conclusion that after his confession to Stephens he never seriously thought of reverting to his old profession. He had passed out of Guy's and on to the greater stage of the world, to flash like a bright meteor across the literary heavens, and sink, in the brilliance of all his youthful promise, into a consumptive's grave four years later. It is, perhaps, permissible at this stage of the tale, its conclusion, to ask the question which naturally occurs to every Keats lover, namely, "In how far did Guy's Hospital and the years he spent here, influence the poet?" Or, in other words, how did his medical career stand amidst the multitudinous other influences that reacted upon him? I have tried to answer this question to my own satisfaction, but I must confess that the conclusions have not satisfied me. A wide and extended search through his works and letters has revealed no passage, reference or note that I could accept as even indirect evidence that his medical work has influenced his poetry. In fact no one, from the mere reading of his poems or letters, would ever infer that he had had the remotest acquaintance with sickness or hospital life. Coleridge and Shelley, both morbidly inquisitive into the realm of medicine, have far more direct medical allusions than I have been able to find in Keats' writings. When the latter does touch upon disease it is in the way and after the fashion of a layman. In his poems he hardly ever mentions anything that is directly of interest in this respect. In his letters, however, he has on several occasions referred to his brother's illness, and at these times one is struck with the fact that he uses common and not technical terms, such as "fever" for "pyrexia," "spitting of blood," for "hæmoptysis," the sick headache, soreness, a swelling, and so on. I have particularly attempted to find such passages since, according to Cowden Clarke, Keats was reckoned, in his Guy's days, at least after his exam., as one who knew his work fairly well. "With all his self-styled unfitness for the work," says his friend, "I was informed that at his examination he displayed an amount of acquirement which surprised his fellow students, who had scarcely any other associations with him than that of a cheerful, crotchety rhymester. He once talked with me, on my complaining of a stomach derangement, with remarkable decision of opinion, describing the functions and actions of the organ with the clearness, and I presume technical precision, of an adult practitioner. The stomach, he said, being like a brood of callow nestlings (opening

his capacious mouth), yearning and gaping for sustenance, etc." And yet, though one finds no direct allusions to his medical experience, can one honestly doubt that it did not influence him? It may be that he went through his hospital course as a discharge of a duty he owed his guardian, as many of us do, finding in after life that our true vocation lay in another direction, the law, authorship, politics, commerce, but even then his environment must have influenced him, enlarged his purview and broadened his compassion for suffering and strengthened his pity and charity. It seems to me that Dr. Richardson, in the article already quoted, has laid too little stress on this aspect of the question. For my part, I prefer to see, in the restraint of that pathetic sonnet, "When I have fears that I may cease to be," in the second stanza of the "Ode to a Nightingale," where he speaks of forgetting—

that thou has ever known
The weariness, the fever and the fret,
Here where men sit and hear each other groan,
Where palsy shakes a few, sad, last grey hairs,
Where youth grows pale and spectre-like and dies.

and in the many other passages that are scattered througout his poems, direct proof of that result and therefore an indirect testimony to the fact that his sojourn at Guy's enriched his mind and was not without its effect upon his work.

In conclusion, it is perhaps worth while to point out what are the chief sources of our information regarding his earlier years. It is to be regretted that there is no standrad life of the poet; what does duty for it is Forman's valuable edition of the letters in four volumes—a mine of information to which a good memoir is prefixed. A fairly good resumé appears in the Dictionary of National Biography, while Colvin's "Life" and Dr. Richardson's article have already been mentioned. A short paper, not very full, appears in the "Hampstead Annual" from the pen of Sir Samuel Wilks. W. M. Rossetti's "Life" contains little about the poet's earlier years, and Masson's essay is more a critical study than a biography. Amongst the rarer books that can be consulted one would place M. Gothein's excellent "Leben und Werke" easily first. Lord Haughton's "Remains" are valuable, and for a critical study, the essays of James Russel Lowell and Angellier's "De Joh. Keatsii Vita," while for the particulars concerning contemporary history Feltoe's "Memorials of South," our own "Biographical History," the back numbers of "Macmillan" and the "Gentleman's Magazine" and the old files of the "Daily Post" may be consulted.

To us Guy's men, leading the life that he led, walking the wards that he trod, though under changed conditions and amidst altered surroundings, the history of his sojourn at this hospital must necessarily be of interest. We have no monument to remember him by except the collected edition of his works which is available to all of us. Let us trust that in the near future his portrait or bust will figure within our gates, and in the meantime reflect that, whether it does or does not,

till the Future dares
Forget the Past, his fate and name shall be
An echo and a light unto eternity.

Specialities.

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Messrs. Solmon Ody, Ltd., 7, New Oxford Street, London, W., the well-known orthopædic specialists, have invented an appliance which will be found most helpful and comforting to persons suffering from pes planus.

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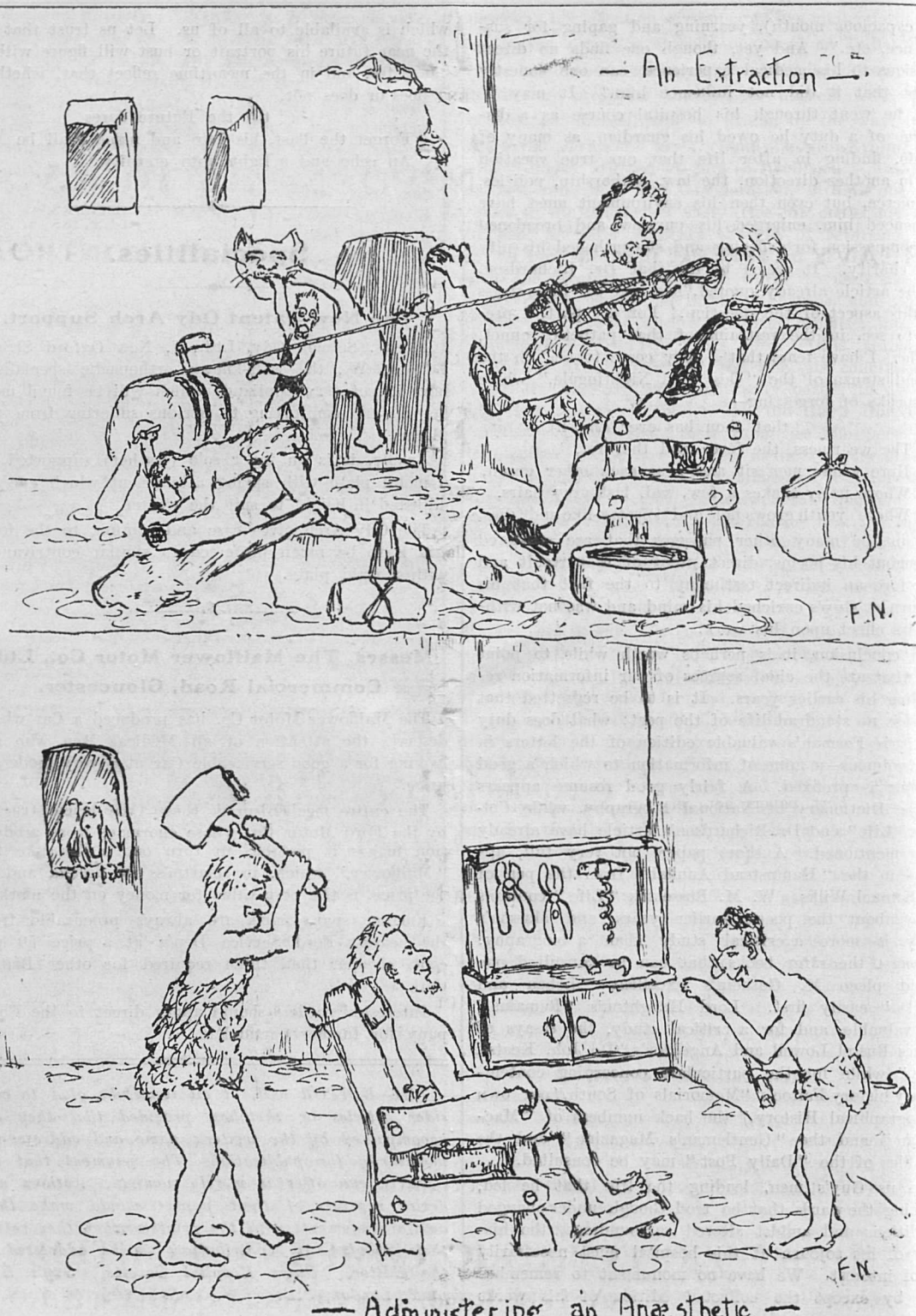
THE EDITOR will, at all times, be glad to consider articles or sketches, provided that they are accompanied by the writer's name and address, not necessarily for publication. The payment that the GAZETTE *can offer is merely nominal. Authors who desire reprints of their papers should make their own arrangements with the printers when they return their proofs. All contributions to be addressed to the Editor, "Guy's Hospital Gazette," Guy's Hospital, London, S.E.*



PREHISTORIC DENTISTRY.

Perforation of Second Lower Molar by Mandibular Nerve.

We are indebted to Mr. J. B. Parfitt, Dental Surgeon to this Hospital for permission to publish the following interesting case, which he recently reported to the British Dental Association and which appears to be unique, since, as far as one can gather, the only cases recorded are those in which the inferior dental nerve perforated a third lower molar, but never a second molar.

The patient was a lady of about 25 years of age, small and slightly built. She complained of "neuralgic" pain in the lower jaw on the left side.

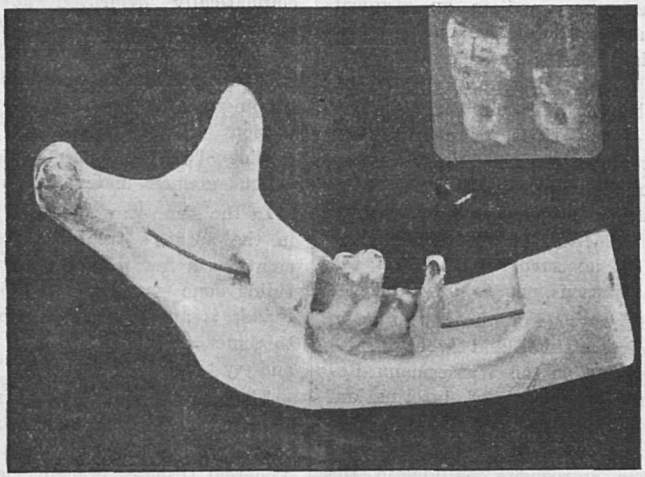
The second lower bicuspid and first molar were missing on the left side, the second molar was badly broken down, and the third molar just appearing through the soft tissues behind it.

Gas was administered on 9th September, 1920, and the two teeth removed. The extraction was difficult on account of their very firm implantation. Immediately the roots of the second molar were extracted it was noticed that each was perforated by a foramen running in an antero-posterior direction, and on examining the patient it was found that she had an anæsthetic area bounded roughly by the middle line, a vertical line passing through the mental foramen, the lower lip and the lower border of the mandible. She suffered little or no pain, and recovery was uneventful, although the anæsthesia persists.

The illustration shows the teeth mounted on a plaster of Paris model of a jaw with a wire representing the mandibular nerve, and (inset) the roots of the second molar with their foramin.

On placing the fractured surface of the roots in correct relation the foramina were in alignment with one another, the third molar had several slight grooves in its under surface and side, one of which may have been in relation with the nerve.

No section has yet been taken of the roots so it is not possible to say whether the nerve was surrounded by dentine or only by cementin.



By permission of the Scientific Editor of "The British Dental Journal."

Reviews.

Syphilis and Its Treatment. By Wilfrid S. Fox, M.A., M.D.Cantab., M.R.C.P.London. (Messrs. H. K. Lewis & Co., Ltd.) Price 36s.

This book strikes the writer as being essentially one for the dermatologist. The various skin manifestations of secondary and tertiary syphilis are legion, and each one is described in detail and adorned with a wealth of illustration—coloured and otherwise. All these illustrations are taken from life, and, besides being beautiful works of art, they must also represent conditions actually seen, but unfortunately the ordinary individual never seems to come across such cases. Perhaps it is the widespread use of salvarsan which is banishing these splendid syphilides from our out-patients, but we must comfort ourselves with the thought that what the student loses the patient gains—Dare quam accipere—in fact. Anyhow the purchaser becomes

the possessor of a beautiful collection of pictures, which the author spent many years in acquiring at St. George's Hospital and at the Seamen's Hospital, Greenwich. Pictures, like everything else, have advanced in value, and this no doubt accounts for the fact that thirty-six shillings are asked for a book of less than two hundred pages.

The interest of the ordinary individual, however, in syphilitic skin lesions is mainly an academical one. Time was no doubt when medical men waged many a battle royal as to whether their patients had a papulo-squamous syphilide or psoriasis, mais nous avons changé tout ça. The application of Herr Wassermann's discovery would have settled the matter one way or the other, and in an atypical syphilide a Wassermann Reaction is the only certain way of clinching the diagnosis. Even dermatologists, when they diagnose a syphilide, generally have no objection to dotting the i's of their diagnosis by having a Wassermann done. It is, of course, horribly bad form to belittle the evidence derived from physical examination of the patient, but we have all heard eminent physicians discuss learnedly exactly why a lump in the abdomen must be either liver or spleen, and have felt no surprise when on the postmortem room table it turns out to be kidney.

But all this is by the way. For those who make the study of skins their pastime, and who despise such short-cuts to knowledge as the Wassermann Reaction, the book is indeed a mine of information. From the practical point of view one is sorry that the author makes no mention of the dark-ground method of detecting the spirochæta pallida in the scraping from a sore. It is a simple and easy investigation, and one which takes only a few minutes to complete, and the evidence which it may afford is absolute and final. In fact if every suspicious-looking sore was investigated in this way, there would be far less of the material to be found from which such books as this are made.

A scheme of treatment is sketchily outlined. As regards arseno-benzene medication, the author recommends three courses of treatment during the first, two during the second, and one during the third year of treatment, a course consisting of six weekly injections of novarsenobillon representing a total of 3·75 grammes for men and 3·15 grammes for women. Surely far more salvarsan than the meagre amount contained in the above series of injections can be given with complete safety, the exhibition of which would increase the possibility of destroying the spirochætæ, before they had had time to entrench themselves in the more remote fastnesses of the body. As regards mercury, the author mentions the various methods of giving it, but seems unable to make up his mind as to whether the continuous or the intermittent treatment is to be preferred. The writer could not make up his mind either, and a careful perusal of the chapters on treatment left him bewildered rather than instructed. A student, who buys a book entitled "Syphilis and its Treatment" will probably expect to find a definite and detailed scheme of treatment laid down for each year that the patient is under observation, such, for example, as McDonagh epitomises in his recent book. Of course many of McDonagh's views are not generally accepted, but he does detail his treatment, which Dr. Fox most unfortunately does not.

Another disappointing feature is the author's handling of neuro-syphilis. This vast subject, which has increased so alarmingly in recent years, is dismissed in less than three pages. The outworn theory—so emphatically disproved at the "Réunion Neurologique," held recently in Paris—that the giving of salvarsan is dangerous in this condition is emphasised, and the brilliant results, which often follow repeated tapping of the thecal canal after an intravenous injection of the drug, are not mentioned. Early meningeal cases sometimes improve in the most marvellous manner under this treatment.

In the same way one does not feel much confidence in the author's treatment of congenital syphilis; he mentions a few methods, but does not give a decided ruling one way or the other. Consequently the reader is apt to close the book in despair and turn to some other source where he can get more definite and systematic instruction.

There is the inevitable warning against the seriousness of syphilis as it affects the public health, and the work of the National Council for Combating Venereal Diseases is mentioned. Personally the writer would like to see no practising medical men on the staff of this society. There are serious stories in circulation to the effect that patients who read the advertisements of the N.C.C.V.D. in the lay press often write to it for advice, and it is suggested that if their social position seems to warrant it, the names of certain medical men who specialise in the treatment of venereal diseases are sent to them. And rumour hath it that the names of these medical men are not always unconnected with the N.C.C.V.D. The medical profession is a great and honourable one, and it is difficult to believe that practices so contrary to the whole spirit of medicine can exist, but its honour should be jealously guarded and its fair name not allowed to be tarnished by rumours—baseless though they probably are—which credit it with the devious methods of a City bucket-shop. One would like, therefore, to have an official statement that such unprofessional conduct has never occurred.

There is a very interesting note on the history of the disease, and the author disagrees with the general opinion that the return of Columbus synchronised with the introduction of syphilis to the civilised world. He gives reasons for believing that the plague of Baal-Peor, which the Israelites contracted

after "associating" with the Midianitish women, and in which twenty-four thousand of them perished, was really syphilis. If so it must have been a very *virulent* infection!

In conclusion one can say that there is only one thing wrong with this book and that is its title. If this were changed to "Syphilis of the Skin," one would have nothing but praise for it as an excellent example of medical belles-lettres, but in a book called "*Syphilis and its Treatment*" dermatological syphilis should not be emphasised to the exclusion of other vastly more important syphilitic manifestations. The student is very apt to get the impression that the cutaneous lesions of the disease are the most serious, whereas they are as nought in comparison with what happens, when the dread symptoms of involvement of the nervous or vascular systems appear. But of course a dermatologist, who writes a book on syphilis, is naturally inclined to look at things from his own point of view.

The Pocket Anatomy. By C. H. Fagge, M.B., M.S.Lond., F.R.C.S. 8th edition. (Messrs. Ballière, Tindall & Cox.) Price

This book should prove of use to the student of anatomy who wishes to revise one certain structure in its entirety, with the part before him. This obviously is the intention of the writer, and under such circumstances the book is to be recommended. If, on the other hand, the "Pocket Fagge" had been intended merely to usurp the position of a text-book on anatomy, or to save the student his one and only *method of learning and appreciating the relation of* one structure to another—to wit, by means of actually dissecting—then such a book could only be condemned. That the book has reached its eighth edition shows its popularity and its utility. The edition has been re-written in old terminology to fit in with the *modern* day teaching.

On Diseases of the Lungs and Pleuræ including Tuberculosis and Mediastinal Growths. By Sir R. Douglas Powell, Bt., K.C.V.O., M.D., and P. Horton Smith Hartley, C.V.O., M.D. Sixth Edition. (Messrs. H. K. Lewis & Co., Ltd.) Price 42s.

This book is a monument to the thoroughness and clinical acumen of the authors. The description of the various pulmonary disorders are characterised by extreme clarity, and full appreciation of the relative importance which should be assigned to each. The subject matter is well illustrated, but the addition of further reproductions of microscopical sections, *e.g.*, with reference to emphysema would be of value.

In the chapter dealing with physical examination of the chest we failed to find any reference to the fact that the bruit d'airain can be elicited by digital percussion of the sternum, which is of advantage in excluding the possibility of deception by the metallic sound produced by coin percussion.

The section dealing with the mechanism of respiration is excellently written and contains many new and highly important facts, whilst the masterful and unbiassed manner with which the authors have dealt with pulmonary tuberculosis will alone ensure this book a place amongst medical classics.

The entire work is characterised by the scientific accuracy with which signs and symptoms are correlated with pathological changes, and convincing reasons are given in support of any line of treatment advocated.

No book is more worthy of attentive perusal by all those who desire to gain an intelligent insight into this great branch of medical science.

The Seventh Edition of *Manson's Tropical Diseases* is announced for publication by Messrs. Cassell & Co., Ltd. The work has been much enlarged, and appears in a new format.

Football.

RUGBY.

GUY'S v. GLOUCESTER.

Kind indeed were the elements for this match at Honor Oak Park on February 19th, and a great game was the result. The encounter had been much looked forward to by the many enthusiasts who follow Guy's and much was the need felt of the promised stand that is to be. Literally hundreds could not get seats and also many did not come to the ground because of the hopelessness of doing aught else but standing by the ropes.

Three Internationals played for Gloucester, all forwards, T. Voyce, G. Holford and S. Smart, also Guy's had three on their side, W. D. Doherty, J. A. Krige and H. Graham-Davies. Splendidly they played, the whole six of them, and the display of *their latest recruit to International honours*, H. Graham-Davies, was very fine. His re-appearance after his bad knock out against Cambridge was a great success.

Our forwards fairly got on top of the Gloucester men at first. True we got a good many free kicks given us, all the same Doherty, Taylor, Reitz and Shelswell were in their best form, and behind them Bekker, Van Schalkwijk, Krige and Graham-Davies, with Olivier were splendid in their saving. Van Schalkwijk kicked with the length and accuracy of a master. Again and again were Gloucester driven right back by these kicks. Then some infringment led to a penalty in our favour, Van Schalkwijk goaling from an easy position. Splendidly our men passed just after this and the ball eventually reached Davies who sent Krige in. Neser's kick only just failed. Once or twice Dix, the visitors' scrum half, and England's reserve half, got the ball away and Gloucester looked well in the running for a score, but Millington was put into touch and our forwards came irresistibly back to Gloucester's 25, where from another "free" Van Schalkwijk cleverly dropped a goal. Although leading by 9 points the hard and well trained pack opposed to us with their three star men, also Ayliffe and the veteran Hall, always doing good work, gave us unceasing cause for watchfulness. Then just before half time Bekker, who appeared to be the master of Dix, got Van Schalkwijk moving to the left. The field went across to bar the movement. Instantly Van Schalkwijk changed direction and Krige came away to the right after Van Schalkwijk had passed to him. At a great pace he broke through and close in passed to Graham-Davies who got right behind for Van Schalkwijk to goal. A penalty against us in our 25, well taken by Robbins,

enabled Gloucester to register a goal, so at half time we led by 14 points to 3 points.

Early in the second half Steyn got in a kick that was not accurate and Webb fielding the misdirected ball very smartly scored a try wide of the posts. A magnificent kick by Robbins converting the same. To detail the close game that ensued till time would be wearisome, no further scoring took place. The Gloucester men had more of the game, but defence prevailed. Dix was, one fears, put off by being constantly pulled up. Nothing disconcerts so much. Neither Steyn nor Daneel had much opportunity. Often one has in these reports criticised different players, one trusts never unkindly, for that reason it gave one pleasure indeed to watch the great improvement in the tackling and the wonderful game our halves and centres put up, playing as they were behind our best pack at its best. Van Schalkwijk's move by which he initiated the play that led to our second try was brainy in the extreme.

The Cup Ties are on us. Physical fitness is the one thing to be attained by the XV. Each man must get himself into a fatigue proof and thoroughly hard condition.

Final score:—Guy's, 3 goals (2 penalties) 1 try (14 points), Gloucester 1 try (3 points).

Guy's Team.—W. Olivier, C. L. Steyn, J. A. Krige, H. Graham-Davies, A. Daneel, F. Bekker, J. G. Van Schalkwijk, W. D. Doherty, F. W. Reitz, A. H. Shelswell, A. H. Van Zyl, R. F. H. Duncan, E. E. Neser, W. H. Taylor, C. Marais.

GUY'S v. OLD LEYSIANS.

There were a good many absentees from the Hospital's usual XV. on Saturday, February 26th, when the above sides met, but those who represented the Hospital were quite strong enough to inflict a rather heavy defeat on the Old Boys. For them it must be said they have only a small membership, no "A" team to draw from, and when players get crocked it is often very difficult to fill the vacant places. But you never hear of the Old Leysians scratching a match, or making excuses, they are real sportsmen in every sense.

The game had not long been in progress when Daneel opened the scoring, after the halves and threequarters had shown some smart handling. The kick at goal failed, and the next kick, taken also by Van Schalkwijk hit the crossbar. The try had been gained by Steyn who received from Shelswell. The forward made the opening beautifully, eluding several would-be tacklers before he cleared the way for the eventual scorer. Daneel got another look in as the passing was all in his direction, but the Old Boys at this stage had thrown attack to the winds and were intent only on defence, so that Daneel was several times held, and Krige was tackled severely on more than one occasion. Duncan, by smart following up, picked up a missed catch, which the sun in the Leysians' eyes probably caused, and scored behind the posts, and before the interval Daneel scored again, Van Schalkwijk goaling.

At half time Krige retired for a few minutes, but he was soon back again and played very pluckily to the end, some of his runs being very fine. Steyn was also in top form. Bekker and Daneel as well. Daneel made one long sprint that never looked like being stopped, but he was firmly held on the line. Steyn was too fast for James so the budding wingman had no chance. This second half Steyn got a couple of tries, Krige one, Neser one. This was richly earned as Neser had played particularly well. His kick at goal was not quite successful, but Daneel landed a beauty, from almost the touch line. Another forward who was at his best was Taylor; he gained a try as a sort of wind up to a good afternoon's work, and as Van Schalkwijk goaled Guy's ran out easy winners by 3 goals 6 tries (33 points) to 1 goal (5 points). The Leysian try was gained by Gould and the conversion was made by Philp.

Guy's Team.—W. Olivier, R. James, C. L. Steyn, J. A. Krige, A. Daneel, F. Bekker, J. Van Schalkwijk, R. F. H. Duncan, A. H. Van Zyl, E. E. Neser, A. H. Shelswell, W. H. Taylor, H. Amm, N. H. Eckhoff, W. H. Mill.

Hockey.

GUY'S v. ST. BART.'S HOSPITAL.

The game was played at Winchmore Hill on Saturday, 19th February, and resulted in a win for Guy's by 2 goals to nil. Guy's were without F. E. Graham-Bonnalie and B. M. Tonkin, E. G. Smallbone and H. G. Close filling the positions.

The first half was evenly contested though L. E. Owen on two separate occasions managed to penetrate the opposing defence. In the second spell Guy's held the upper hand, but no further goals were added. The forwards on several occasions narrowly missed scoring, many golden opportunities being lost owing to extra hard hitting and bad passing. K. Hooper at centre half did some valuable spoiling, and opened up the game well.

Guy's Team.—C. V. Baugh, C. G. Bowen, W. F. Hurdle, A. L. McKay, K. Hooper, S. C. Olver, E. G. Smallbone, L. E. Owen (Capt.), J. W. Schollum, H. G. Close, and W. S. Hunt.

GUY'S v. CHRIST'S COLLEGE, CAMBRIDGE.

On Tuesday, February 22nd, Guy's lost to Christ's, Cambridge, by 4 goals to 1. The game was fast and more even than the score indicates, it being the finish of our opponents which enabled them to win a decisive victory without domineering the game to any large extent. Their forwards were always more dangerous than ours, but no side showed superiority in defence. For Guy's, K. Hooper played a fine game at centre half and C. V. T. Baugh effected some good clearances. Our goal was scored by L. E. Owen, who was the most prominent of our forwards.

Guy's Team.—C. V. T. Baugh, C. G. Bowen, W. F. Hurdle, R. McKay, K. Hooper, H. Slater, W. S. Hunt, J. V. Schollum, B. M. Tonkin (Capt.), L. E. Owen, E. G. Smallbone.

Other Results—

2nd XI.—Feb. 19th v. Bellevue I., lost 6—8.
Feb. 26th. v. Gunnersbury II.,

Birth.

SCOTT.—On Sunday, February 13th, the wife of Dr. E. D. Scott, of a daughter.

Ed.—M. E. S.

GUY'S HOSPITAL GAZETTE.

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Passim.

THE War Memorial is now very nearly finished, and, when the pillars have been cleaned into uniformity and the names have been inscribed, it will be a very handsome addition to the architecture of the Hospital. By the time these words appear the final decision as to the disposition of the outside railings will have been made. What that decision is to be we cannot say, but we understand that the suggestion is to remove the two square stone pillars upon which the gates are now hung and to replace them at the outer or peripheral ends of the railings. The railings themselves cannot be removed. They act as an essential barrier to two important gangways which must be retained inside the Hospital precincts. But they will probably be modified so as to extend in a curve from their present starting points up to the central columns of the Memorial Arch. It seems to be universally agreed that it would be infinitely better, from the artistic point of view, to do away with them altogether. For the moment this is clearly impossible, and their proposed new distribution, with the gates hung in the new arch, will be a distinct improvement which will in no way prejudice further alteration at a future date should such prove practicable.

The present pathway alongside Hunt's House, leading to the College, will disappear and a new one be made to pass through the passage on the right of the arch (looking from the Park). The intervening space, we understand, when it has been cleared of the various odds and ends which at present occupy it, will be covered with grass.

AT their meeting last Monday the War Memorial Committee gave very careful consideration to the wording of the inscriptions to be placed over the Arch, and we are glad to say they incorporated one or two suggestions which have been made at our request by correspondents to the GAZETTE. It will, of course, be understood that this is the Committee's final decision. It is obviously impossible to please everyone, but we hope that the majority of subscribers will be satisfied. On the outside of the arch will be the words "Erected by the friends of 110 Guy's men who gave their lives in the Great War," and on the inside the inscription will read:—

"To the honour of those who came through,
To the memory of those who died.
1914–1919."

In addition, over each panel bearing the names of those who died, will be the words "In Memoriam."

The unveiling of the Memorial will probably take place on July 15th, when the Prince of

Wales will visit the Hospital for this purpose and also to open the new building in the Park which is rapidly nearing completion. Although the official opening of this building will not be until July, it is hoped to make use of the lower floors before that date, and thus to make possible the removal of the very inadequate premises in which the massage department is at present housed. While on the subject of new buildings we might add that the new baby ward should be ready by the end of the month. The conversion of a very unpromising site has been carried out with considerable skill, but the new ward will necessarily be very inadequate for its purpose and we hope that a new and better one will be provided as soon as some more money is forthcoming.

The War Memorial volume of The Reports, the last issue of the old series, will not appear until the unveiling of the Memorial Arch has taken place as it is proposed to include a description of this ceremony and a photograph of the completed Arch.

Finally may we draw the attention of our readers to the list of names of Guy's men who lost their lives in the war which appears on p. 116 The names will not be inscribed until April 15th, and we would ask our readers to notify the Secretary of the War Memorial Committee of any errors or omissions of which they may be aware before that date.

A Provisional Committee of the University of London Union Society has now been elected. The names are, Messrs. B. I. Evans, J. R. Gammell, C. H. C. Toussaint, J. Mould, R. C. Rham, A. T. Davis, L. A. W. Thurgood, R. Goodman, E. M. Newman, R. H. Walmsley, Misses. S. Myers, M. Burwell, J. Elliot, G. Brooke, V. Anderson. The first business which this Committee has undertaken is to draw up a provisional constitution which will have been submitted to a General Meeting at University College on Friday, March 18th. If this Constitution is accepted by the General Meeting, and it is almost certain to be except in points of detail, original members will be those who join within two months of that date. The advantages offered to original members will be considerable. In the first place, as we have pointed out before, they will be admitted without election, and they will not be called on to pay the entrance fee of 10s. 6d. which will be imposed on those who join after the time limit for original members has expired. The subscription will be One Guinea. Original members, who pay their guinea before the two months are up, will only pay 10s. 6d. for the second year, which will start in September next, and for all members the payment of 5 years subscription will entitle the members to life membership. Original members will therefore become life members by paying four and a half guineas over a period of just over four years. Other members will have to pay five and a half guineas over a period of five years for the same privilege.

At the moment no premises have been definitely secured, but it seems probable that it will be possible to get possession of a number of army huts, known as the "Pickwick Hut," in Bloomsbury. If this scheme materialises it should be possible to establish very comfortable quarters of a temporary nature, while negotiations are being carried on with a view to the acquisition of suitable permanent premises. Our readers know our views on the value of the Union to members of the University, and especially to hospital men. May we once more express a hope that the original members of the University of London Union Society will contain a large and representative number of Guy's men?

The new notice board in the Colonnade to which reference was made last week is, we

understand, the property of the Clubs' Union, and is to take the place of the very inadequate board at present provided for the various clubs. Each Club will have its name inscribed over one of the compartments, and in this way the searcher after information will have a much easier task than in the past. The Medical School notices will be transferred to the old Clubs' Union Board.

The Oxford and Cambridge Club has recently been revived and it has been decided to hold a dinner towards the end of May, and to ask Dr. Newton Pitt to take the Chair. The objects of the Club are merely to keep Oxford and Cambridge men at Guy's in touch with one another and to give them the opportunity of one or more social gatherings in the year.

This week two of the Cups from the Smoking Room have made a journey and returned. On Tuesday last the Association XI. defeated Bart's on the St. Thomas's ground at Chiswick by 5 goals to 1, and at Richmond on Wednesday the XV. secured a victory over the same opponents by the narrow margin of 3 points to 0. In the Association match Bart's were unfortunate in losing their right back from an injured knee, but apart from this their men seemed to tire more quickly and the difference between the sides was more marked as time went on.

At Richmond we imagine that there was no one, except perhaps some Bart's men, who did not confess to some surprise at the low scoring. Going down in the train we heard people talking glibly of "twenty points" and in the end it was just one try. Nor did our men by any means have all the best of the game. We were left in complete uncertainty as to the result until the whistle blew. Personally we would not have had it otherwise. Even scoring keeps a game going better than anything, and on Wednesday the pace was fast and furious right up to the end. Bart's played a really fine game reminiscent of last year's match. A little luck and they might very easily have won. As it was, the balance of luck was against Guy's, as Krige's knee gave out quite early, and Reitz had to be taken out of the pack. But luck or no luck, the Bart's XV. were very nearly a match for ours, and one only wonders that, with two such teams to pick from, the United Hospitals are ever beaten.

Our very hearty congratulations to Messrs. Doherty and Couch and their teams on the victories which have crowned the conclusion of a highly successful season.

A Guy's Reunion Dinner at Liverpool.

A Reunion Dinner of Guy's men residing in Liverpool and District was held at the North Western Hotel, Liverpool, on Friday, March 11th, 1921.

The following were present:—Messrs. O. Bowen (1873—77), in the Chair; Hugh E. Jones (1880—5), (Vice-Chairman), J. Lloyd Roberts (1883—91), W. N. East (1892—99), J. H. Jones (1892—98), H. L. Whitlow (1899—1901), E. C. Lowe (1899—1905), £H. S. Cranston (1900—02), W. Johnson (1902—20), J. Pryce-Davies (1902—11), H. Mather (1906—14).

Letters of regret at their inability to be present were received from:—Professor W. Ramsden, and Messrs. F. S. Brereton, E. Claxton, F. T. Paul, J. P. Pendlebury, G. H. Steveni, E. R. Stone, J. E. Nevins, W. G. Parker.

After dinner and the usual loyal toasts it was decided that:—

1. The dinner be an annual affair.
2. It shall be called "The Liverpool and District Guy's Reunion Dinner."
3. It shall be held in Liverpool, towards the end of November.
4. Mr Horace Mather be elected Hon. Secretary.
5. A notice be sent to the Guy's Gazette, so that anyone who is in the District may communicate with the Honorary Secretary, 73 Rodney Street, Liverpool, should his name be omitted.

A very pleasant evening was spent in reminiscences of Guy's.

Dyspnœa and Tracheotomy.

CLINICAL LECTURE BY Mr. W. M. MOLLISON.

Gentlemen,—Dyspnœa is, in its severe degrees, a condition incompatible with life, and when of rapid onset precipitates a surgical emergency and necessitates immediate operation to open the air-way below the obstruction, probably by means of tracheotomy.

Even when dyspnœa is gradual in onset, relief may only be obtainable by tracheotomy. On the other hand there are many conditions that produce dyspnœa in which surgical interference is powerless.

Let us draw up a scheme to include the various causes of dyspnœa, and then concentrate on those where the surgeon can give relief. Since the development of direct laryngoscopy, tracheoscopy and bronchoscopy, fewer cases come to tracheotomy, as obstructions can be removed through the natural passages.

Causes of Dyspnœa.

A. General Diseases.

Affections of the Lungs.

Affections of the Heart.

Affections of the Kidneys.

Affections of the Nervous System, central and peripheral.

B. Local affections that cause dyspnœa by preventing the entrance of air to the lungs.

1. Obstructions in the passages common to air and food.

2. Obstructions in the air passages only, either larynx, trachea or bronchi.

a. Obstruction from outside.

b. Obstructions in the lumen of the passages.

c. Obstructions arising in the walls of the tubes.

Considering the group A. first, it is obviously beyond my province to discuss the many diseases that frequently cause dyspnœa; you will have seen cases of advanced heart disease labouring for breath; cases of dyspnœa in uræmia; cases of pneumonia, phthisis and many of you unfortunately cases of gas poisoning. You will easily be able to add many conditions from your experience and thus fill in this section fully. In passing, it may be noted that it is extremely difficult to distinguish between dyspnœa of pneumonia and of laryngeal obstruction in the case of young children.

One condition may be referred to here that affects not only the larynx, but other parts of the body, this is angeioneurotic œdema; this is a condition that may be compared to urticaria, areas of œdema occur in the subcutaneous tissues quite rapidly, the swelling may be on the hand, the face, the eyelids, the mouth, or any part; at another time the larynx may be the site of the œdema and the loose tissues of the ary-epiglottic folds swell rapidly and obstruct the entrance with the resulting dyspnœa. Fortunately this is a rarity, but tracheotomy may be necessary to save the patient's life.

Let us pass to group B. Local affections, and deal with the passages common to food and air, B, 1. Here is a diagram of a sagittal section through the head: above, the hard and soft palates, the teeth, the posterior pharyngeal wall behind. here the tongue, the epiglottis, the arytenoid cartilages, and the aryteno-epiglottidian folds: above, the nose and naso-pharynx. From the level of the soft palate to that of the arytenoids the passage is common to air and food, and it is thus obvious that obstructions here will cause dyspnœa.

Obstructions are sometimes mechanical, but frequently inflammation spreads from the original focus to the larynx and produces dyspnœa by œdema of the laryngeal entrance.

Foreign bodies may be so large as to lodge at the back of the mouth and block the entrance to the larynx; there is a specimen in the Museum of a mass of meat thus impacted and caused death. This is a rare accident in normal people, but it may happen in the case of epileptics who are seized with a fit while eating or while holding something in the teeth. I have seen such a case, though fortunately without fatal result. A boot-maker was holding one of those rubber heels in his teeth preparatory to fastening it to the boot he was repairing; he had a fit and on recovery the heel had disappeared and he could not swallow; on examining the œsophagus the heel was found and removed: had this only fallen to the back of the throat it was quite large enough to have caused obstruction to the air passage.

The Tongue may act as a foreign body by dropping back against the pharyngeal wall and thus obstruct the common air-food passage; this occurs, as you know, in patients under anæsthetics, and gives the reason for holding the jaw forward that is so essential to a clear air-way, because by holding the jaw the tongue is pulled forward. In other conditions of unconsciousness the tongue may fall back, in some fits, cerebral hæmorrhage, and so on.

There are two inflammatory conditions of the tongue that may lead to dyspnœa; *acute parenchymatous glossitis*, and *abscess of the tongue*. *Acute parenchymatous glossitis* is, as it's name implies, an acute inflammation of the substance of the tongue. The tongue becomes dark in colour, with glazed surface, the swelling is so great that the organ may project from the mouth; the condition is very painful. Inflammation may spread backwards and involve the larynx and so cause dyspnœa by œdema of the aryteno-epiglottidian folds. It is most important, therefore, to institute active treatment early. Longitudinal incisions must be made on either side of the mid-line (unless the infection has only affected one side), free bleeding follows with relief in a short time. Abscess of the tongue usually occurs at the posterior part on either side of the mid-line; it causes a very painful swelling of the tongue, making swallowing almost impossible; as before œdema of the larynx is apt to follow unless the abscess is opened; to do this make an incision in the mid-line of the tongue to avoid vessels and from this incision pass sinus forceps outwards into the abscess.

Always have tracheotomy instruments at hand when performing both the above operations in case sudden spasm of the glottis should occur; let the anæsthetic be chloroform.

It is probable that abscesses at the back of the tongue are occasionally the cause of sudden death through œdema glottidis. Some years ago I saw a specimen that supports this suggestion; a hawker, who had died in a few moments, was brought in dead to the hospital. At the autopsy nothing could be found to account for death excepting a small abscess about the size of the tip of a finger at the back of the tongue. It is true there was no œdema of the glottis to be seen, but œdema in this position disappears very rapidly after death.

Let us now pass to a consideration of the swellings of the posterior pharyngeal wall that may cause obstruction. Abscesses and growths are both possible causes. Here in the diagram is the pharyngeal wall; it consists of the constrictor muscles and aponeurosis covered in front with mucous membrane; posteriorly is the vertebral column, the prevertebral muscles and the prevertebral fascia, between this and the pharyngeal wall are lymphatic glands.

The common form of retropharyngeal abscess is due to an acute inflammation of these glands; enlargement of the glands follows infection from the mucous membrane or from the tonsils, later when pus forms the abscess pushes forward the pharyngeal wall either opposite the back of the tongue or lower down. In any case, in a young child the swelling obstructs the entrance to the larynx. The resulting dyspnœa closely resembles that of laryngitis, catarrhal or diphtheritic. It is almost always a condition of young children and must be excluded in all cases of dyspnœa. Its treatment is simple, an incision is made into the abscess through the mouth; gag the child, make the incision with a knife having only a quarter of an inch of its blade exposed; guide the knife either by touch or under illumination; immediately have the child turned on to its face to prevent pus from entering the larynx. Give no anæsthetic, and have tracheotomy instruments at hand.

The other form of retropharyngeal abscess is one due to tuberculous disease of the cervical spine; onset is, of course, slow, and other signs of cervical caries will guide one to the diagnosis; such abscesses are not to be opened through the mouth unless in an emergency, but through the neck.

In adults, growths arising in the pharyngeal wall may become so large as to overhang the laryngeal opening; the diagnosis is never in doubt, and when dyspnœa results tracheotomy will be required; before that stage is reached diathermy gives encouraging improvement.

We pass now to group B, section 2, "Obstructions to the air passages." The causes may be well considered under three headings:—

a. Obstructions from outside.

b. Obstructions in the lumen.

c. Obstructions due to lesions of the walls of the air tubes.

a. Pressure from outside may arise by garrotting and strangling. There have been two

cases lately of strangling. I saw the larynx from one of the cases; it was characterised by numerous petechial hæmorrhages in the mucous membrane. These conditions naturally produce death by dyspnœa. An enlarged thyroid causes pressure from without, notably in cases of retro-sternal adenoma. Those of you who have seen thyroid operations will doubtless have seen cases where the adenoma had passed down behind the sternum and produced a considerable amount of dyspnœ, embarrassing the anæsthetist considerably till it is brought out from behind the sternum into the neck.

Particularly does thyroid tumour give rise to dyspnœa when it is malignant. I saw a patient recently who had had half of her thyroid removed some years ago for dyspnœa, and she recovered from the operation. But gradually as time went on she began to get more and more dyspnœa and began coughing up blood. Her larynx was pushed over to the right side by a very hard thyroid swelling which was ulcerating into the trachea, and the ulceration was the cause of the blood she was bringing up.

Pressure by malignant glands affords another source of dyspnœa. Lower down mediastinal tumours, or masses of tuberculous glands, may press on the trachea or bronchi. In infants an enlarged thymus may cause dyspnœa. Dr. Cameron has told me of two or three cases. A very interesting feature about them is that the dyspnœa is worse on extending the head and so bringing pressure to bear on the trachea. On relieving the pressure by flexing the head on the trunk the dyspnœa diminishes.

b. Obstructions in the passages. Here is a very pretty little specimen from the Museum which shows you a foreign body impacted in the larynx. You see a little piece of bone which has been fastened in position. It was there, post-mortem, impacted actually between the vocal cords. That produced dyspnœa for two reasons: one, a mechanical reason, because the foreign body actually obstructed the passage of air into the larynx; the other, more important, a spasmodic reason; the presence of a foreign body on the vocal cords produces acute spasm of the laryngeal muscles. Foreign bodies of all sorts and sizes have been found in the air passages, and they may cause acute dyspnœa as in that child, resulting in its death. The foreign body must be of a certain size, and must stick in the larynx, because as soon as the foreign body gets into the trachea through the glottis it has so much more room that it may not produce acute dyspnœa at all, but only occasional attacks of dyspnœa in conjunction with other symptoms, which we cannot go into just now. Here are a larynx, trachea, and bronchi; you can see how large is the lumen of the trachea and bronchi.; the finger will pass into that bronchus quite easily; and the trachea is a good deal larger than the bronchus. It is the sticking of foreign bodies in the larynx, or in the glottis, that is so dangerous from the point of view of acute dyspnœa. Once they go through you get a different series of symptoms, no less dangerous, but not so urgent.

The treatment of foreign bodies in the air passages has been absolutely revolutionised by direct examination of the tubes, or what is known as tracheoscopy and bronchoscopy, and by specially devised forceps the majority of the foreign bodies can be removed through the larynx. But there still remains a very considerable number of foreign bodies which it is extremely difficult to extract through the tube passed through the vocal cords and so into the bronchus—such foreign bodies for example as beans and peas that become swollen and soft in the air passages. That difficulty can be largely overcome by performing a tracheotomy and passing the bronchoscope direct into the trachea. Examination of this specimen shows how much more easily you will get at these foreign bodies when you employ this method. You must not think it is a disgrace to do tracheotomy to extract your foreign body; bronchoscopy is a very specialised manipulation, and a tracheotomy is simple and enables a larger and shorter tube to be used.

We have not really time now to go into the whole question of foreign bodies, but what I have shown you and said about foreign bodies will give you an idea of how they produce dyspnœa.

Amongst other obstructions inside the air passages, do not forget the foreign bodies, blood and pus. The question is extremely important and belongs really to the subject of anæsthetics and operations on the upper respiratory tract. But remember when you are dealing with operations on the upper respiratory tract that cocaine has often been used and that the sensitiveness of the pharyngeal and laryn-

geal mucous membrane is much reduced, and the cough reflex is greatly reduced. In consequence blood may collect in the pharynx and pass into the air passages and cause serious obstruction unless a very strict watch be kept on the patient.

B.2. We come next to affections of the walls of the passages themselves.

It will be impossible to deal with all conditions in the time at our disposal, so that we will confine ourselves to children while dealing with this section of the subject. The following conditions will be referred to :—

1. Webbing of the vocal cords.

2. Congenital laryngeal stridor.

3. Laryngismus stridulus.

4. Inflammatory affections, *i.e.*, acute laryngitis, catarrhal, diphtheritic, pneumococcal.

5. Papillomata.

Let us begin with a very interesting and very rare condition, a specimen of which we are fortunate enough to have in the Museum, viz., 1. *Webbing of the vocal cords.* If you look down that specimen, the larynx of a child nine months old, you will see that the opening in the glottis is reduced to a very small space indeed. This webbing always occurs in the front part of the larynx, and consists in a membrane joining together the anterior parts of the vocal cords. In that case the joining together is extreme. Sometimes in mild cases the patient grows up with no ill effects. In that specimen you have there, the patient died from the effects of dyspnœa. The condition was present at birth, but the child survived till the age of nine months, when death occurred from dyspnœa, and in the account of the specimen it is stated that the glottis was reduced to a chink less than one-eighth of an inch across.

2. Another congenital condition producing dyspnœa is *congenital laryngeal stridor;* it is fairly well established now that this is due to an exaggeration of the normal narrow laryngeal entrance in children. Here is a specimen of the larynx in an infant; you will see the slit-like opening between the ary-epiglottic folds; should this become narrower still it is obvious that air would have great difficulty in entering and stridor would occur.

The diagnosis of this condition rests on the point that it is congenital, that from the first days of life the child crows, not all the time necessarily, but at intervals, becoming worse if restless or excited, since the delicate folds become drawn together by the more rapid inspiratory air stream.

Another important and more frequent cause of dyspnœa is the condition known as (3) *laryngismus stridulus.* This occurs in feeble children or those the subject of rickets. It is a form of laryngeal stridor of sudden onset and non-inflammatory. It probably never occurs in breast-fed children. The attacks are generally at night, the child wakes struggling for breath though it may have been apparently quite well on going to sleep. Inspiratory efforts are accompanied by stridor, and owing to this inability to inspire air through the glottis the muscular efforts cause retraction of the lower ribs. Usually after one or two minutes the spasm passes and inspiration is restored though some crowing and brassy cough remain for 12—24 hours. There is often some predisposing cause for the attacks, such as nasal catarrh, adenoids or large tonsils.

The diagnosis of this cause for dyspnœa is important, since it is quite wrong to perform tracheotomy in view of the fact the larynx is normal.

We must now pass to (4) *inflammatory affections of the larynx.* Inflammation of the larynx produces dyspnœa by causing swelling of the vocal cords or œdema of the glottis or of the laryngeal entrance. Here is a very good specimen. There you see the larynx from behind, and here are the aryteno-epiglottidian folds which are quite thin. In that other bottle (indicated) these folds are very thick, sausage-shaped swellings. These folds, particularly in children, are very loosely made, and œdema causes much swelling of them, as well as of the mucous membrane of the epiglottis; the air space is thus so much reduced that severe dyspnœa is the result.

The conditions which produce that œdema are : Inflammations either primarily of the larynx, or as frequently, if not more frequently, inflammations of the parts adjacent to the larynx. I spoke just now of abscess at the back of the tongue, which produces an area of inflammation around it and then causes œdema of the aryteno-epiglottidian folds. Similarly any acute inflammation of the pharyngeal wall or the tonsils may produce œdema of the aryteno-epiglottidian folds, as may growths and ulcerations in these parts.

The second acute inflammatory laryngeal infection that causes dyspnœa and demands tracheotomy most often is diphtheria. It is rare to find diphtheria of the larynx without some sign of the disease in the pharynx. Not only does diphtheria produce acute inflammation of all the laryngeal mucous membrane, but it gives rise to the typical false membrane that spreads over the cords and passes through the glottis into the trachea, and no doubt some of you have seen in the post-mortem room specimens where not only the trachea but the bronchi were covered with diphtheritic membrane.

It is clear that great narrowing of the glottis may thus occur and that narrowing may also occur in the trachea itself. At the same time absoption of toxins from the extensive area involved will itself lead to severe constitutional symptoms, symptoms of cardiac failure that closely resemble those produced by mechanical obstruction of the air-way. It is often difficult to distinguish the cyanosis of laryngeal obstruction from that of diphtheritic intoxication; tracheotomy will give relief in the former, but will certainly not do so in the latter condition.

There are other laryngeal infections that produce acute laryngitis, streptococcal and pneumococcal, but in cases of urgency the bacteriology of the infection cannot be investigated.

5. Lastly, *papillomata* of the vocal cords; papillomata are particularly prone to occur in children, they are usually multiple, and are scattered along the true cords. By their bulk they produce obstruction, and obviously the obstruction will be progressive as the papillomata increase in size. Before the days of direct laryngoscopy, tracheotomy often was performed in these cases, but now it seldom is required, as the growths can be removed quite easily under direct vision through a tube or by means of suspension laryngoscopy.

When is tracheotomy necessary to relieve the dyspnœa? It is clear that the answer to this question depends largely on diagnosis of the cause. It should never be performed for laryngismus stridulus, it should not be needed for cases of papilloma of the larynx, nor for cases of congenital laryngeal stridor. Cases of webbing of the cords may require tracheotomy as a preliminary to other treatment, but this need seldom be done as an emergency operation.

There remain cases of acute catarrhal laryngitis and diphtheria. Examination of the pharynx will usually give evidence of diphtheria, but even if it does not, the case may be treated as one of diphtheria as far as the medicinal treatment is concerned; anti-diphtheritic serum should be given in large doses, say 10,000 units, or even more in quite young children. In no case be in a hurry to perform tracheotomy; unless there is evidence of cardiac embarrassment children can recover from a great amount of dyspnœa. Give chloral and bromide by the rectum, place the child in a warm bath, give oxygen and wait for an hour or two; frequently it is possible to tide over the severe stage of dyspnœa and allow the anti-diphtheritic serum to take effect. If after this the child is becoming more dyspnœic, tracheotomy is needed. Remember that tracheotomy in a small child is a difficult operation, and when you are driven to it, operate to give yourself and the child every chance of success; have a good light, if possible a head lamp, infiltrate the skin and subcutaneous tissues in front of the the neck $\frac{1}{2}$ per cent. solution of novocain and adrenalin 1 : 60,000; get the neck in a somewhat extended position and the head held by a competent assistant; stick to the mid-line, not only for the skin incision, but for the deeper parts and feel and see the trachea before incising it. It is best to perform as low a tracheotomy as possible; this makes certain of avoiding the cricoid, damage to which gives rise to serious difficulties later, and it gives a better chance of avoiding membrane that may have spread to the trachea.

Lastly, remove the tube as soon as possible: at the end of 24 hours is best, at the end of 48 next best. Before attempting the removal give chloral and bromide and keep the child under their influence for some hours. When the tube is retained longer than three days, it is often a matter of the utmost difficulty to discard it at all.

Appointments.

W. E. Tanner, M.S., F.R.C.S., Surgeon to Out-Patients, The Evelina Hospital for Sick Children, Southwark.

W. Johnson, M.D., M.R.C.P., Asst. Physician to the Southern Hospital, Liverpool (March, 1920), and Asst. Physician to the Royal Liverpool Children's Hospital (March, 1921).

Correspondence.

To the Editor of Guy's Hospital Gazette.

The Heart in Muscular Exercise.

Sir,—I hope that you will allow me space for a brief reply to Dr. Abrahams' exceedingly interesting letter published in your last issue..

It is with considerable diffidence that I again approach the subject of the Heart in Muscular Exercise. While Dr. Abrahams is speaking from experience, my ideas on the subject are limited to those derived from a study of other people's work. (In obtaining material for my paper I was indebted in particular to the monograph of Bainbridge and Lewis.)

Nevertheless, I must say that there is one point upon which I cannot agree with Dr. Abrahams. I still maintain that a trained man is able to "attain to the required output without the same need for acceleration of the pulse as is felt by a sedentary person." It is true that the trained person can, if necessary, increase his pulse-rate to a very large extent, but, as Starling says:—"The trained man will have a considerable range over which the output per beat can be increased by increasing inflow without alteration of rhythm. In the untrained man this margin will be smaller, so that . . . quickening of the heart-beat will be sooner brought into action." Bainbridge is equally emphatic upon this point, while also recognizing the more rapid return to normal of the pulse-rate in a trained person.

On the other hand, I have asked Dr. Pembrey about this point, and he tells me that, in his experience, persons trained for a *particular form of exercise* can certainly perform a given amount of it with less need for acceleration of the pulse-rate than is felt by the untrained person.

One might therefore conclude that apparent discrepancies between various recorded results might be explained if one considered the effects of practice at any particular exercise.

A man, however well trained, will not economize and save himself effort the first time he does an exercise new to him. So that a less well-trained person, who knows the exercise, may exhibit a less marked circulatory response than the well-trained man who does not know the exercise. But the latter *does more work* in doing the exercise. This seems to be borne out by observations upon a friend, who is a good gymnast, and myself, who am not. In our first exercise, which consisted of ten "pumps" upon the parallel bars, my friend's pulse-rate went from 80 to 116, and returned to 80 within two minutes, while mine rose from 80 to 156, and at the end of two minutes was still beating at a rate of 100 per minute.

In our second exercise, which was a quarter-mile run, my pulse-rate rose from 68 to 160, and at the end of three minutes was again down to 80, whilst that of my friend rose from 72 to 164, and at the end of three minutes was still 108. He was better trained as regards gymnastics; I was in better training for a run.

In conclusion I should like to express my appreciation of the interesting points which Dr. Abrahams raised in his letter.—I am, Sir, Yours very truly,

J. A. CURRIE.

5th County of London Armoured Car Company.

Sir,—The 5th County of London Armoured Car Company T.F., has been formed from the disbanded 3rd County of London Yeomanry (Sharpshooters). The Headquarters, one of the best in London, are at 90, Henry Street, St. John's Wood, near St. John's Wood Station.

The provisional establishment consists of 14 officers and 178 other ranks, together with 4 armoured cars, 2 instructional lorries, and 3 motor-cycles.

The old Yeomanry Regiment had a troop composed entirely of Medical students and this Unit is now recruiting principally from the Hospitals, Banks, Stock Exchange, Lloyds, and the Technical Institutes of London. It is hoped to keep up this high standard of enlistment and we should very shortly be at full strength.

It is an entirely new branch of the Territorial Army, and should appeal to those who wish to take up or continue some form of military training. Four to six men comprise a crew and this alone should induce a few friends to join and so form a complete crew. It is not essential to have any previous technical knowledge as driving and maintenance of cars will form part of the training. In addition this Unit will be trained in the Hotchkiss gun and revolver. The annual camp this year, July 23rd to August 6th, will be at the Training Centre of the Tank Corps at Lulworth, just outside Lulworth Cove, a well-known beauty spot on the Dorset Coast.

The days for recruiting are Tuesdays and Fridays between 6 p.m. and 9 p.m., but should any of

those interested in this new Unit care to come and pay a visit to the Headquarters the Adjutant will be pleased to make an appointment with them.—Yours faithfully,

W. PENN PASTFELL,
Capt. and Adjt.

5th County of London Armoured Car Coy.

Guy's Men at Middlesex Hospital.

SIR,—In the correspondence which has been going on in your columns upon the subject of Guy's men who are connected with the Middlesex Hospital, no mention has so far been made of Sir Henry Morris, who, although not upon the active staff, is still Consulting Surgeon to the Hospital. Sir Henry Morris was President of the Royal College of Surgeons in 1906—9, and is I believe one of the few remaining dressers of John Hilton. His name, together with those of Sir Henry Howse and Sir George Savage, was to be seen in the late eighties inscribed on one of the window-panes in the old residents' dining-room. I remember that the window-sash had at some time been inverted and that it was necessary to use a mirror to read the names on the glass,—I am, etc,

CHARLES SPURRELL.

St. Andrew's Hospital (Bow, E.3).

DEAR MR. EDITOR,—Though I am a regular reader of the GAZETTE, I somehow missed your issue of February 5th with its friendly little paragraph about my double association with Guy's and Middlesex. It gives me great pleasure to know that my old school has not forgotten me as I had begun to fear.. I went down to the Guy's v. Middlesex Rugger Cup-tie the other day, feeling that I could not lose whatever happened. I appreciated the generous Guy's cheer which greeted the plucky try scored by Middlesex against the present miraculous Guy's team, and came away with curiously mixed sensations of pride and "pip." I shall hope for a different result next time, and so no doubt will my colleagues and friends Greeves, Bankart and Bennett, who, as links between Middlesex and Guy's, share with me the strain of divided allegiance which a loyal link must needs bear. Is it indiscreet to express the hope that if ever Guy's seeks a recruit for its staff outside it will choose a Middlesex man and so confirm by reciprocity the blending of the traditions of two great Hospitals?—Yours very truly,

W. SAMPSON HANDLEY.

36, Harley Street, W. 1.
March 8th, 1921.

A Palatable Tæniafuge.

SIR,—With reference to the letter in the issue of the GAZETTE of February 19th, from a "Guy's Man in Abyssinia," I am wondering if your correspondent has tried the anthelmentic powers of Pomegranate, to which I referred in a previous letter, and which you were kind enough to publish in the GAZETTE of November 16th, 1918.

During my residence in India I never heard of this drug failing in its action and I can say from personal experience that it is quite palatable, moreover, it admits of being flavoured to taste.

Briefly the modus operandi is as follows:—On the first day a light milk diet is to be taken, and on retiring to bed Pulv. Jalapæ Co. i. dr. On the second day no food may be taken until the treatment is complete. At 10 p.m. take vi. fl. oz. of the extract prepared as under:—

"Macerate three ounces of fresh Pomegranate Root in one pint of distilled water, filter and evaporate down to xii. fl. oz. Flavour to suit individual taste."

At 12 noon the patient is directed to repeat the dose of vi. fl. oz. of the extract. One hour later a purge is given.—I am, Sir, Yours faithfully,

H. G. R. CANNING.

Guy's Hospital, S.E. 1.
February 23rd, 1921.

Change of Address.

Geoffrey L. Attwater, M.D., 7, Terrace Road, Maidstone, Kent.

T. F. Brown, D.S.O., Park Avenue, Burwood, Sydney.

A. P. Marsh (Capt.), Dental Clinic, Durrington Camp, Salisbury Plain.

G. F. Peters, Parkside, Brighton Road, Sutton, Surrey.

Arthur Thomas, Surg.-Commander, R.N., c/o Admiral Grant, C.B., R.N., 68 Carlisle Mansions, Westminster, S.W.

Charles Spurrell, F.R.C.S., St. Andrews Hospital, Bow, E. 3.

F. K. Escritt, Capt., R.A.M.C., c/o A.D.M.S., Baghdad, Mesopotamian Expeditionary Force.

G. Black, 60, High Street, Uxbridge. Telephone 42, Uxbridge.

Health Week in 1921.

The Secretary of the Health Week Committee, appointed by the Royal Sanitary Institute, announces that H.M. the King and H.M. the Queen have again graciously accorded their patronage to "Health Week," which will be held this year during the month of October.

Pass List.

University of London.

M.D., November, 1920.

Geoffrey L. Attwater.

L.D.S.

Mechanical Dentistry and Dental Metallurgy, February, 1921.

W. J. Williams.
†D. H. Couch.
B. Crisp.
L. G. Gray.
F. H. Hayns.
A. L. Hodgkinson.
R. Hofmeyer.
J. A. Hudson.
R. S. Matthews.
H. F. Miles.
R. H. Muller.
A. E. Nelson.
L. B. Osborne.
J. B. Roberts.
S. E. Sennitt.
K. G. Sharvill.
E. A. Sheppard.
A. E. Tidd.
G. F. C. Turle.
†F. A. Walker.
*H. Wayman.
*C. H. Archer.
*D. H. Batty.
*E. A. T. Bradly.
*T. C. Butler.
*L. S. Carter.
*H. A. Clarke.
*R. F. H. Duncan.
*T. G. Edwards.
*C. D. Farris.
*L. J. Godden.
*E. Greco.
*C. R. Hardwicke.
*J. B. Hine.
*W. F. Howe.
*O. P. James.
*F. A. Kerrison.
*S. E. Lewis.
*S. A. Madgwick.
*E. H. Marshall.
*S. Massy.
*R. Maxwell.
*D. H. Oliver.
*D. H. Overend.
*J. R. Palfry.
*C. T. Pomeroy.
*G. A. Sargent.
*E. G. Smallbone.
*C. H. Stevens.
*W. H. Taylor.
*G. L. Thompson.
*C. P. Urbani.
*E. A. J. Van Noorden
*C. B. Wilson.
*O. H. M. Woodbridge.
†L. F. Handford.
†E. A. Lloyd.
†R. C. May.
†D. A. Parsons.
†A. F. Porter.
†W. O. Sims.
†S. D. Neal.
†J. F. Allen.
†D. J. Baker.
†E. V. Hayes.
†J. E. Lloyd.
†L. Nurick.
†G. L. Shearns.
†G. M. R. Van der Merwe.
†G. J. Van Schalkwijk.
†B. J. Celliers.
†A. S. V. Daniels.
†C. H. A. Fido.
†W. J. Hide.
†J. G. Lloyd.
†F. R. Payne.
†E. L. Sprong.
†F. A. J. Zettel.
†I. M. Zondagh.
†R. C. Andrews.
†A. J. Britz.
†G. A. Lawson-Brown.
†E. Z. C. Pearson.
†L. N. Theron.
†N. S. Campbell.
†A. Clarke.
†V. R. Estment.
†G. W. Griffith.
†V. R. Morgan.
†H. Radin.
†L. P. Tupling.

*Mechanical Dentistry only.

†Dental Metallurgy only.

Guy's Employees' Association.

By kind permission of Dr. P. P. Laidlaw, a meeting of the employees of the Hospital, and of the Medical and Dental Schools was held in the Pathological Theatre on Thursday, February 17th. There was an excellent attendance of employees, representative of every department in the Hospital and Schools.

Mr. S. H. Croucher (Chairman) addressed the meeting and explained the objects of the gathering, and proceeded to detail the desirability of forming an association for all employees connected with Guy's Hospital. There was an urgent need for such an organisation to bring about a closer co-ordination between the staffs of the various departments of the Hospital and Schools.

Soon after the war efforts were made to reorganise an association which existed prior to 1914, but for some unknown reason, the support given was very poor and the project allowed to lapse.

Now that most people had settled down, there was a keener desire to have an organised association to bring about a feeling of good fellowship and understanding amongst all concerned. The Chairman then asked that a formal resolution be moved "That an association of the employees of the Hospital and of the Medical and Dental Schools be formed." This was proposed by Mr. Lane (Works Dept.) and seconded by Mr. J. H. E. Winston and carried unanimously.

A suggestion by Mr. Hancock, that a personal invitation to attend the next meeting be sent by the Chief of the Administrative Staff of each Department was agreed to unanimously.

The Chairman then suggested that a temporary Committee be formed to draw up draft rules for presentation at the next general meeting; this was adopted and the following Committee appointed: Miss Beardoe-Grundy, Messrs. Winston, Beale, Hancock, Brereton, Lane, Taggett and Whitbread.

The Chairman finally announced that Mr. Eason, the Superintendent had kindly consented to act as the Association's first President, and Prof. Johnston (Medical School), and Mr. Hopson (Dental School) as Vice-Presidents.

A hearty vote of thanks to the Chairman was carried with applause.

Fencing.

Amateur Championship.—The representative from Guy's Hospital reached the round previous to the semi-final.

Guy's Men who gave up their lives in the Great War.

We publish below a list of the names of the Guy's men who were killed in the War. In order that the work of carving these names on the War Memorial Arch may begin as soon as possible, we request our readers to examine this list and to notify the Secretary of the War Memorial Committee of any mistakes, or of any names that have been omitted or wrongfully included.

We would also call attention to the proofs of the war Memorial Volume of the Guy's Hospital Reports, which are posted in various parts of the Hospital for correction.

Ackroyd, H.
Allen, N.
Atkinson, N. M. H.
Ball, M. E.
Beale-Browne, T. R.
Bearblock, W. J.
Beard, F. G. V.
Berncastle, H. F. G.
Berry, P. H.
Bond, A. B.
Bouic, J. A.
Brogden, I. R. R.
Browne, W, Denis
Buck, A. D.
Chaning-Pearce, W. T.
Clifford, A. C.
Cocks, J. Stanley
Collins, R. T.
Dennett, T. F. P. T.
Dinan, G. A.
Dingley, W.
Dix, C. B.
Eccles, H. D.
Edmonds, J. A.
Evans, J. E. R.
Faulks, Edgar
Fraser, E. L.
Gardinner, I. J.
Gardner, A. L.
German, H. B.
Gibson, H. G.
Glaisby, K.
Godsill, Stanley
Gough, B. B.
Hamilton, E. T. E.
Harrison, S. S. B.
Hartnell, E. B.
Haynes, C. G.
Hayward, M. C.
Henderson, T. E.
Hogbin, H. F. T.
Hollands, W. G.
Hopkins, H. L.
Horton, J. H.
Howard, C. R.
Hugill, Valentine ?
Hugh-Jones, A. H.
James, J. S. H.
Jones, E. L.
Kelsey, A. E.
Kennedy, R. S.
Knaggs, F. H.
Knight, R. V.
Kynaston, A. E. F.
Lacey, W. S.
Lansdown, W. M.
Leckie, Malcolm
Llarina, E. F.
Logan, F. T. B.
Lowe, F. A.
Marshall, B. G.
Marshall, H. M.
Mash, O. N.
Maxwell, J. E.
Mayston, J. H.
Miller, G. S.
Monk, G. B.
Moore, L. W.
Morrish, D. B.
Nesby, H. B.
Nichols, W. H.
Oates, J. L.
Palmer, A. H.
Palmer, H. J.
Palmer, J. S.
Parry-Jones, O. G.
Pearce, D. G.
Peatfield, S. J.
Pern, M.
Pryn, W. R.
Pryor, W. R. ?
Reckitt, C. E.
Rees, M. J.
Richards, E. H. R.
Robertson, E. G.
Robertson, J. C.
Robinson, W. B.
Ross, J. H.
Rowell, G.
Sandoe, M. W. A.
Saw, N. H. W.
Scott-Pillow, H. M.
Seabrooke, A.
Shepherd-Turnham, N. P.
Shorland, G.
Small, F. D.
Smith, Gayton Warwick
Smith, Douglas W.
Snell, H.
Snell, N.
Snow, C. F.
Sowerby, V. H.
Spong, R. W.
Stainer, C. H.
Stanwell, W. A.
Stephen, L. H. Y.
Steyn, S. S. L.
Tilbury, A.
Tolehurst, St. J. A. M.
Townsend, T. A.
Traill, A.
Traill, K. R.
Waghorn, L. P.
Watson, C. F. W.
Watt, N. L.
Webster, E. M.
Weinberg, A.
Weller, C.
Wentworth, H. P.

Guy's and its Dental Surgeons.*

BY FRANK J. PEARCE, L.D.S.Eng., D.D.S.Penn.

BEFORE describing the foundation of Guy's, it may possibly interest you if I, very briefly, outline the connection of another great hospital with this part of London. St. Thomas's Hospital stood originally not very far from this spot, and was intimately connected with Guy's for a long time after its foundation; indeed, it was the original intention of the founder of the latter that the two should have an even closer connection than they eventually had. St. Thomas's Hospital probably had its origin in Norman times, as there is mention of an "Almery" existing at that time in this neighbourhood. Early in the thirteenth century this was refounded, primarily as a religious institution for the poor and infirm, under the control of the Augustinian Order. Later this was dedicated to St. Thomas à Becket, and was popularly known as "Bekket's Spyttell." This institution, in common with most religious establishments, was confiscated in the reign of Henry VIII., but eventually he consented to its reconstitution as the Hospital of the Holy Trinity. Henry died, but his son, Edward VI., invited the Lord Mayor to undertake its preservation, and the hospital was reopened under the name of "The King's Hospital,' in compliment to the Sovereign. The old popular name persisted, however, and as a compromise it was finally decided to call it St. Thomas's, not, however, after Thomas à Becket, but after St. Thomas the Apostle. A new Charter was granted, and the hospital remained without much alteration from 1552 until 1704, when Thomas Guy, a bookseller in the City of London and a member of the Stationers' Company, was invited to accept the office of Governor. Thomas Guy took a great interest in this institution, possibly because he was born within a short distance of it in the year 1644 or 1645.

*Presidential Address delivered to the Metropolitan Branch on December 8, 1920.

Whilst Governor, he was a liberal subscriber to all its good works, and in addition he erected three new wards at his own expense, and later some additional wards were built abutting on St. Thomas's Street, the street by which most approach the hospital. This hospital remained until the building of new London Bridge, which necessitated an alteration in the direction of the roadway. It may interest you to know that one of the stone alcoves from old London Bridge is situated in what we call the Park, just outside the Medical School buildings. The Park is also interesting as having been the site of a burial pit for those who died in the plague, but I must not digress from my subject. To endeavour to tell of the many historical facts connected with this part of London would need much more time than is available.

St. Thomas's was pulled down finally in 1862 to make way for the railway. In 1721, the minutes of St. Thomas's record the first formal arrangements made for Thomas Guy's new hospital for incurables, which was to be erected close by. The foundations of this new hospital were laid in 1722. Thomas Guy personally superintended its erection, and the fabric was roofed just before the founder died, December 27, 1724. He had, however, left it in trust to others to complete his work, and endowed it with money and lands to enable it to maintain 400 patients. In the front quadrangle as you came in this evening you will have noticed a statue of our founder, Thomas Guy, with the following inscription on it: "Thomas Guy, sole Founder of this Hospital in his lifetime." No mean gift even in these days, but for those times an almost unprecedented beneficence, and the benefactions I have mentioned were by no means all he gave.

In the following year, 1725, on the 6th January, Guy's Hospital was opened and sixty patients were admitted. From the preceding remarks you will realize that two hospitals existed in that time close together, St. Thomas's and Guy's. Guy's was founded on the model of St. Thomas's, and had its own medical and surgical staff, but no separate medical school. The staff, however, were permitted to receive pupils and dressers, inclusive of apprentices, and the fees received were divided between the staffs of the two hospitals. Certain of the lectures were delivered at Guy's, whilst others were given at St. Thomas's. Pupils were permitted to attend the practice at both hospitals till 1760, when a quarrel arose between the two hospitals relative to the reciprocal attendance of students at operations, and all intercourse was broken off. Eight years later, however, the governors of Guy's resolved "That the barrier between this hospital and St. Thomas's be taken down and that the pupils of St. Thomas's has [*sic*] free leave to see not only the operations, but also all the other practice of this hospital." St. Thomas's also passed a similar resolution. Thenceforward the hospitals were known as the "United Hospitals," and sometimes as the Borough Hospitals; in fact, they were regarded as twins.

In 1824 differences sprang up between the two hospitals which led to the separation of the two schools, and the inauguration, in 1825, of Guy's Medical School as a separate institution. Even after this separation some degree of unity remained between the two hospitals as the privilege of a pupil at one school attending the practice of the other remained. Guy's Medical School flourished whilst that of St. Thomas's declined, and the bond between them was finally severed in 1836 in consequence of the refusal of St. Thomas's to admit Guy's men to attend operations advertised to take place at St. Thomas's. A row between the students of the two schools resulted, and it was expected to develop into a 'free' fight, as the students of each school collected for this purpose. But the police were called in, and it is chronicled that nine Guy's men were taken to the police office and charged. These were committed for trial and appeared at the next Assizes, where they were reprimanded and bound over to keep the peace. It is interesting to note that the *esprit de corps*, which has always animated all those connected with Guy's, was well exampled at that time, as after the Assizes the staff of Guy's held a meeting and the following resolution was passed: "We, the undersigned officers and teachers in the School of Guy's Hospital, hereby assure the gentlemen composing the classes, of our sense of the great attention and uniform propriety of conduct evinced by them on all occasions, and express our unqualified opinion that nothing has occurred to deprive them of our confidence and regard." Then follow the names of the staff. The chaplain gave a separate testimonial as follows: "As chaplain of Guy's Hospital, I have read lectures on moral philosophy to as many of the students of the Medical School as had leisure and inclination to attend, and have uniformly received from them the most respectful attention. I have also had opportunities of observing the deportment of the students generally, which has always seemed to me most becoming and orderly. Signed, Frederick Denison Maurice."

It is worthy of notice that these letures on "Moral Philosophy" were scheduled along with those on Medical and Surgical subjects, and appeared in the syllabus. Maurice's successor in the chaplaincy also delivered a course When the lectures were discontinued I have not discovered, but I do not remember any being given in my time.

Now having sketched briefly the foundation of the hospital and of the medical school, I wish to show you that whilst the medical side of the hospital can point with much pride to such names as Addison

and Bright, and the surgical side can also with equal pride mention the names of Astley Cooper and Hilton, we, of the dental side, can also look back to a very distinguished list of dental surgeons, among the earlier ones Fox, Bell and Salter. I propose to tell you about these men who have not only shed lustre on the profession to which we all belong, but more particularly on the Hospital and School, of which those of us who are connected with Guy's are so proud.

Joseph Fox was the first dentist attached to Guy's Hospital. I am not at all sure that Guy's cannot lay claim to being the first hospital in this country to appoint a dental surgeon. We can, at any rate, confidently claim that Guy's was the first hospital in this country to institute a course of lectures on dental surgery; and these were first delivered by Fox in the spring of 1799, and as part of the spring course in succeeding years. You may remember that at this time Guy's did not possess a separate Medical School, so that these lectures were instituted before the Medical School.

Joseph Fox also published a book on dentistry, which is one of the first, if not the first scientific book published in this country, and written by a practising dentist. Hunter's great work preceded it by some years, but Hunter was not a dentist. Fox's book was published in two parts. The first part was entitled "The Natural History of the Human Teeth, including a particular elucidation of the changes which take place during the second dentition and describing the proper mode of treatment to prevent irregularities of the teeth, to which is added an account of the diseases which affect children during the first dentition." This was printed for Thomas Cox (at his medical library), St. Thomas's Street, Borough, 1803.

The full title of the second volume, published in 1806, is "The History and Treatment of Diseases of the Teeth, the Gums and the Alveolar Processes, with the operations which they respectively require. To which is added observations on other Diseases of the Mouth and the mode of fixing Artificial Teeth." This is the complete book of the two volumes which I hold in my hand, and it is interesting to Guy's men as having formed part of the library of the "Physical Society of Guy's Hospital," which was instituted in 1771, and is the oldest medical society in London, being founded before the Medical Society of London; and at one of its meetings in 1802, Jenner gave an account of the discovery of vaccination. It is reported that Jenner attended on four consecutive nights, having received an express invitation and request from the Society for that purpose. Jenner was elected an Honorary Associate, a distinction which was only conferred on the authors of some great discovery in medicine. I am afraid I am again digressing from my subject, but I find it very difficult not to do so, as so many interesting events have occurred in and around the hospital. Fox's book contains thirteen beautiful copper plates, and was dedicated to Henry Cline, who was at that time lecturer on Anatomy, and Surgeon to St. Thomas's Hospital. Fox's address at the time was 54, Lombard Street, and there he probably practised.

A second edition, again in two parts, of this work was printed in 1814, and is entitled simply: "The Natural History and Diseases of the Human Teeth." On the title page Fox is mentioned as lecturer on the Structure and Diseases of the Teeth at Guy's Hospital, and Surgeon Dentist Extraordinary to their Royal Highnesses the Dukes of Kent and Sussex.

The second edition contained twenty-three copper plates, and in his introduction to this edition, also dedicated to Henry Cline, Fox writes: "An attention to the appearance of the teeth; and a desire to preserve them in a healthy state; and the necessity which exists of procuring relief when affected by disease, are sources of considerable occupation. In the metropolis and large towns, professional men as dentists are enabled to confine their practices to this department alone, but in those situations where surgeons are obliged to undertake medicine and surgery in all their branches, it is necessary that they should be well acquainted with the structure and diseases of the teeth, as of any other part of practice whatsoever." Further on he writes: "Mr. Hunter's publication on the teeth was the first scientific book ever published upon this subject, and as an anatomical work must ever enjoy great celebrity, but not having practically devoted much of his attention to the operations upon the teeth, there can be no reflection upon Mr. Hunter's merit in stating that in many essential points he was wholly but unavoidably deficient; particularly in regard to the right management of the teeth during the second dentition." He also states he found amongst the pupils of Guy's and St. Thomas's Hospitals a great desire to obtain particular information concerning the diseases of the teeth, and it was this which led to his giving a course of lectures. He gratefully acknowledges the assistance he received at that time from Mr. Astley Cooper. We find that by this time he had removed from Lombard Street to Argyll Street. In concluding his introduction, he mentions how gratified he was to find that a second edition was required, and states that during his professional career his great object has been to render this particular line of practice more respectable by engaging the regular surgeon to adopt it, and he trusts that in conjunction with his lectures this work has contributed to that desirable end.

A third edition was published in 1833, after Fox's death, and in the preface it is stated that, notwithstanding twenty years have elapsed since he gave his last attention to the subject, "it is the opinion of good authorities that neither alterations nor additions are required"; and I venture to state that most of us present here to-day can gain knowledge from the perusal of his great work. I regret that I am unable at present to discover much about his parentage or private life, but Fox is said to have been a man "abounding in the best feelings of the human heart, and at the same time possessing undaunted courage and perseverance in every good work." He must have also been very successful in his practice or have been possessed of private means, for he is known to have come to the financial aid of Joseph Lawrence, a Quaker, who had opened a school for the education of the poorest children in this neighbourhood. Lawrence got into financial trouble over this school, probably because of his zeal in the work, and became unable to carry it on. Fox came to his assistance by selling out funded property to the amount of £2,000, and in addition he made himself responsible for a further £4,000.

(To be continued.)

Notices.

The Civic Education League is arranging four courses of lectures on Social subjects during the Summer Term. These will be given by kind permission of the National League for Health, Maternity and Child Welfare, at 4, Tavistock Square, W.C. 1. Miss Norah March, B.Sc., will give a first course of three lectures on "Sex and Social Life," followed by a second course of three lectures dealing with special problems in the same connection. Mr. G. H. Green, B.Sc., B.Litt., will give three lectures on "Social Psychology (dealing, among other things, with the relation of Analytical Psychology to Social Psychology), followed by a second course of three further lectures on more advanced aspects of the same subject. Both courses will treat their topics from an up-to-date but practical point of view, and will be of value to teachers, social workers, health visitors, and others interested in adult education.

The courses will commence on Wednesday, 27th April, and will be continued weekly, with one week's interval (at Whitsuntide) between the first and second courses in each case.

Miss March's course will be at 6 p.m., and Mr. Green's at 7.15 p.m.

Fees: 5s. for each course; 8s. 6d. for two courses together; 15s. for all four courses together.

For Syllabus and all further particulars apply to Miss Margaret Tatton, Secretary, Civic Education League, Leplay House, 65, Belgrave Road, S.W. 1.

Specialities.

Bevan's Advocaat.

MESSRS. BEVAN'S, 146, FENCHURCH STREET, E.C.

Bevan's Advocaat is a Dutch liqueur well known and much appreciated in Holland. Owing to the enterprise of Messrs. Bevan's it has now found its way into England, where it deserves to be equally valued.

It is composed mainly of new laid eggs and the best brandy, and is put on the market in an improved form, more palatable to the English taste.

Bevan's Advocaat is delicious and will be found of service to patients convalescing, as the Preparation is nutritious and easily digested.

Messrs. Bevan's will be pleased to send a sample to Medical Men on application.

Papers by Guy's Men.

C. Westman. (1) Case of Lumbar Displacement of Ten Years' Standing. Rectification.—*Lancet*, Sept. 18th, 1920.

(2) On the Importance of Muscular Relaxation in the Examination of Joints.—*Practitioner*, Feb., 1921.

W. Kelsey Fry, M.C., F.R.C.S., L.D.S. in conjunction with H. D. Gillies, C.B.E., F.R.C.S. A New Principle in the Surgical Treatment of Congenital Cleft Palate and its Mechanical Counterpart.—*British Medical Journal*, March 5th, 1921, p. 335.

F. J. Steward, M.S. (1) Recurrent Epithelioma of Floor of Mouth Treated by Diathermy. (2) Epithelioma of Soft Palate and Fauces on the Right Side and Cheek on the Left Side Treated by Diathermy.—Proc. Roy. Soc. Med., Clinical Section, p. 37.

F. D. Saner, F.R.C.S. Case of Fracture of the Femur and Tibia of the same Leg.—*Ibid.*, p. 45.

A. W. Sheen, C.B.E., M.S. Case of Hypopituarism. —*Ibid.*, p. 47.

Philip Turner, M.S. Case of Cavernous Nævus of the Foot.—*Ibid.*, p. 48.

H. W. Barber, M.D. Three Cases of Dermatitis Scrofulosa.—*Ibid.*, Sec. of Dermatology, p. 33.

H. W. Barber, M.D. (1) Case of Severe Tertiary Syphilis. (2) Case of Xanthoma Multiplex. (3) Case of Almost Complete Alopecia Areata of the Scalp of Five Years' Duration, in which rapid Regrowth of the Hair followed Removal of Tonsils and Adenoids, and subsequent Vaccine Treatment.—*Ibid.*, pp. 51—53.

J. Lewin Payne, M.R.C.S., L.R.C.P., L.D.S. The Invasion of the Pulp Canal by Cenemental Lacunæ.—*British Dental Journal*, March 15th, 1921, p. 235.

THE EDITOR will, at all times, be glad to consider articles or sketches, provided that they are accompanied by the writer's name and address, not necessarily for publication. The payment that the GAZETTE *can offer is merely nominal. Authors who desire reprints of their papers should make their own arrangements with the printers when they return their proofs. All contributions to be addressed to the Editor, "Guy's Hospital Gazette," Guy's Hospital, London, S.E.*

Reviews.

The Croonian Lectures on The Psychology of the Special Senses and their Functional Disorders. By Arthur F. Hurst, M.A., M.D.Oxon., F.R.C.P., Physician and Neurologist to Guy's Hospital, London. (Henry Frowde and Messrs. Hodder and Stoughton. Oxford Medical Publications.) 123p.p. 12s. 6d. net.

We welcome this book by Dr. Hurst replete with those stimulating ideas that we have been led to expect from him. Much of it has already appeared in the Seale Hayne Neurological Transactions, but it is well to have the matters here considered in a consecutive form instead of being dotted about in a series of short articles, and if a thing is worth saying once it is worth saying twice. The book is full of good teaching when it warns us how easily the doctor may make a patient ill or worse by suggesting to him symptoms of which he has had no knowledge before. Dr. Hurst begins with a definition of hysteria. In spite of Dr. Hurst saying it is the "only possible definition of hysteria" it has been preceded by a hundred others, and at least one new one has been put forward since. These definitions show the line along which the definer approaches the disease, Dr. Hurst has been busily employed in curing functional disorders in soldiers and he approaches the condition from the curative point of view. Dr. Reynolds* is frequently considering the monetary value of the accidents in the industrial world and in his definition he approaches the disease from the causative point of view. After discussing the classes of hysterical anæsthesia Dr. Hurst passes on to the Pathogenesis, and it is in this chapter that we find the greatest interest. That a sensory process is an active one just as much as is a motor process is one of those simple facts which is recognised as true as soon as one hears it, but of which one has never thought spontaneously, and which to the best of our knowledge has not been put before us previously by any of our teachers physiological, pathological or clinical. From this he goes on to say as follows: "The simplest explanation of the behaviour of the superficial reflexes in hysterical anæsthesia is that the structural basis of the psychological act of attention consists in some change which leads to a diminution in the resistance offered at each synapsis of the sensory tract. Perhaps this is in the nature of a throwing out of dendrites, or it may depend upon some biochemical change in the material which occupies the space between the dendritic terminations of adjacent neurones. Whatever it may be, the increased resistance which is present when attention is very deficient results in anæsthesia, and at the same time a block is produced in the reflex arc which results in diminution or abolition of the reflex.'

This is one of those brilliant hypotheses which do much to help us in fixing our thoughts along a certain line which we can follow in our actions. But it is no more than a hypothesis. It is not even a theory and certainly not a fact. Although the hypothesis is put forward with all moderation when he first enunciates it Dr. Hurst unfortunately becomes more and more dogmatic as he goes along. Thus, when he applies it to hearing he definitely calls it a theory, and when he passes on to sight we find the following: "It was shown . . . . that the process of listening involved some change at each synapsis in the auditory tract from the cochlea to the cerebral cortex." This was never shown, it was merely suggested that some such change might possibly occur. Dogma such as this is bad in any writer, in a teacher it is worse. Surrounded by students who are only too prone to accept statements as facts without due consideration the teacher has a responsibility that the ordinary writer has not. Dr. Hurst has a double responsibility. At an age when most men are struggling to get a few to listen to them Dr. Hurst has acquired a fame as a teacher to which but few attain at a much later period of their lives, and has had certain privileges granted him for this teaching. An abstention from dogma has permeated the teaching of our school, and we do not believe that any amount of energy or any number of new forms of teaching will compensate us for the loss of it.

We feel inclined to cavil at the title of this book, though to do so is the poorest form of criticism. If there is good stuff in the book it does not matter what the title is and there is very good stuff in this. The function of a title is, however, to attract a person to a book and we fear this may fail to do so. In the first place it deals neither entirely with the special senses nor with all of them. Half the book is taken up with ordinary sensation, and half with hearing and seeing. Smell, taste, and the sensations associated with the proprio-receptive nerves are not considered. In the second place the word psychology seems out of place. True it covers most things now-a-days. When you open a book on the subject you generally find something very abstruse, rather far-fetched, and which the author is careful to explain is entirely distinct from anything physiological. There is none of that here. Except as indicated above it is good sound medicine based upon physiological principles.

T. B. L.

Lancet, Oct. 23rd, 1920, The Causes of Nervous Diseases.

Handbook of Sanitary Law. By B. Burnett Ham, M.D., D.P.H. Eighth Edition. Edited by H. R. Kenwood, C.M.G., M.D., D.P.H. Price 5s.

We are pleased to see another edition of this excellent book, which has been ably brought up to date by Dr. Kenwood. The various new Acts passed since the last edition in 1913, have entailed many additions, and the reorganisation of the Public Health Service under a Ministry of Health has necessitated much revision.

The size of the book is still such that it will fit into one's pocket without causing any undue bulge—one factor in this being the economy of space due to the lavish use of abbreviations, some of which are at first somewhat surprising, for instance B.M.A. means Butter and Margarine Act, and U.S.A. Urban Sanitary Authority. Nevertheless, once used to this the book will be found invaluable to the D.P.H. student when he comes to the legal side of his studies.

Mechanism, Life and Personality. By J. S. Haldane, M.D., LL.D.Lond. (Messrs. John Murray.) Second Edition. Price 6s. net.

This book has a particular appeal to Guy's men in that the first edition was a reproduction of a course of lectures given in the Physiological Department of this Hospital. In the present publication the chapter on Personality has been entirely recast, but in other respects the work remains the same.

At the outset one must acknowledge that to the student whose biological, and other work, is undertaken purely with a view to acquiring that modicum of fact which will satisfy his examiners, this book makes no appeal. It lies out of the rut. Its raison-d'être is a criticism of the inadequacies of the mechanistic point of view from which most of the biologists (and here the sub-group of physiologists is included) of the past century approached their subject. Such a frame of mind has been bequeathed to their followers of to-day, and its persistence is a direct consequence of the reparation of science from philosophy. The cold scorn of the materialist, proud in his "physical laws," for what he considers armchair philosophy has blinded him to the failure of even his imagination to conceive of a "mechanism capable of bringing about the phenomena, fundamentally characteristic for life, of organic maintenance and reproduction." The belief in a "vital principle," with an influence superimposed upon physico-chemical phenomena, is logically even less sound, since in such a dualistic view are inherent the faults of both basal theories.

Too often the present-day physiologist, for example in describing the functions of an organ, prides himself that whereas his forebears examined it in splendid isolation, he emphasises its inter-relation with the other tissues and organs of the body. This pharasaical attitude loses sight of the truth that the environment is an essential part of the individual; that, as Kant phrased it, the world is the world of perception, and thus *within*.

The present work cannot fail to stimulate lively interest among all true students of medicine, qualified or otherwise; the value to the clinician of the true philosophical mind—not that stultifying apathy which too often passes under that name—is unlimited.

Guy's Hospital Reports. Vol. 71. (Vol. 1. Fourth Series.) No. 1, January, 1921. (Henry Frowde and Messrs. Hodder and Stoughton, London.) Price 12s. 6d. net.

The propaganda preliminary to the appearance of the first volume of the new series of the Guy's Hospital Reports had led us all to expect great things, and we can safely say that the volume before us in no way falls short of our high expectations. In so far as it is a review of work that has been going on within the Hospital much of its contents are naturally familiar to those readers who have had the opportunity of following the teaching of many of the contributors. But there is much that appears now for the first time, and the Editor has secured a variety of subject matter sufficiently wide to maintain the interest of the reader and to appeal to all classes of practitioners. It would be an impertinence to criticise the individual articles and we have too much sympathy with the trials of an editor to criticise the Editorial Department. The standard set by the first volume is undeniably high and we can only hope that it will be maintained. It is easy to stimulate enthusiasm over a novelty. To maintain this enthusiasm, once aroused, indefinitely is a difficult task and it will be a reassuring indication of the excellence of the work of the Hospital if subsequent volumes reach the same high limit as Volume One. It will probably be a disappointment to many that the present volume contains a preponderance of articles on medical subjects. This will no doubt be remedied in future volumes, but we notice that papers advertised for inclusion in forthcoming issues are again, for the most part, medical. As the Reports will no doubt be widely read outside the Hospital we hope that Guy's Surgeons will not be backward in demonstrating to the profession the active part that they play in the progress of their art.

Blood-Pictures: An Introduction to the Study of Clinical Hæmatology. By C. Price-Jones, M.B.Lond. (Messrs. John Wright & Sons.) Price 6s. 6d. net.

The appearance of the second edition of this book is warmly to be welcomed, not on account of the modifications since the original publication, but as a sign of its appreciation by clinical workers.

By a ruthless exclusion of methods of investigation which have outworn their utility, the author has been able to present, in a limited bulk, not only an adequate description of necessary technique, but also a summary of the clinical significances of various aberrations from the normal blood-picture. The illustrations show the results of staining by the straightforward standard methods described, and not as is often the case, those which may only be attained by a high degree of technical ability coupled with extreme laboratory advantages.

Whether the variations in lymphoid and polymorphonuclear counts in the healthy adult are as restricted as the text suggests is doubtful, but dogmatic assertion is necessitated by the evident keynote of the work—brevity. In these days of imported tropical infections, we rather regret that no space has been found for a short account of the commoner blood-parasites; such an inclusion would, we think, render the book even more useful to the general practitioner. We are of opinion that the only excuse a clinical clerk can offer for not possessing this book is a complete knowledge of its contents; such a knowledge, we fear, is rare.

"First Aid" to the Injured and Sick. An advanced Ambulance Handbook. By F. J. Warwick, B.A., M.B.Cantab., M.R.C.S., L.S.A., A.K.C.Lond. and A. C. Tunstall, M.D., C.M., F.R.C.S., L.R.C.P.Ed. (Messrs. John Wright & Sons, Ltd., Bristol.) Eleventh edition. 2s. 6d. paper cover, and 5s. leather.

Although intended for First Aid and Ambulance workers, the revised edition of this book has many points of interest to students and nurses. The summary of the common causes of unconsciousness is particularly well arranged. The illustrations are distinct, especially the additional one of the diaphragm, which is one of the best.

Medicamenta Recentia. Published by Messrs. Allen and Hanburys, 1920.

Messrs. Allen & Hanburys have published in a convenient concise form, an alphabetical list of their preparations. Each preparation is accompanied by a short explanatory note which gives the composition, dose and pharmacological action of the particular drug. In addition there is a therapeutic index, designed to facilitate prescribing. The only improvement one feels tempted to suggest to Messrs. Allen & Hanburys is that in or with future editions (a book with such a title demands a constant series of new editions), they should publish a price list of the drugs mentioned in the handbook. Such an addition would render it all the more serviceable to the practitioner.

Surgical Pathology and Morbid Anatomy. By Sir Anthony Bowlby, K.C.B., K.C.M.G., K.C.V.O., F.R.C.S., and Sir Frederick Andrewes, M.D., F.R.S. Seventh Edition. (Messrs. J. & A. Churchill, London. 1920.) Price 30s. net.

A book which has reached its 7th edition need not detain the reviewer long. Briefly its chief faults seem to us to be generic and not individual. No book on surgical pathology can be wholly satisfactory. For what is surgical pathology? We suspect the answer to be "that sort of pathology which a candidate may be asked by a surgeon in a surgical exam." Not having suffered in this way, as yet, we cannot say whether this work fulfils its obligation under such a definition of its title. But we can safely say that its pathology is too brief and its surgery too scanty to be of value to a student of either of these two subjects. And yet no doubt the book has a value for those who know their surgery and their pathology and who wish to correlate the two subjects.

The present edition contains some new material derived from the lessons of the war and the illustrations have been improved and added to. We have no quarrel with the surgery of Sir Anthony Bowlby or with the pathology of Sir Frederick Andrewes. Our complaint is rather that there is not enough of either, and a perusal of the book may lead the student into a false sense of security.

Anæsthetics, Their Uses and Administration. By Dudley W. Buxton, M.D., B.S., M.R.C.P. Sixth Edition. (H. K. Lewis and Co., Ltd., London. 1920.) Price 21s. net.

How many students ever read a book on anæsthetics? Certainly very few. It is more true of anæsthetics than of any other branch of medicine or surgery that the practice teaches better than the printed page. One might go further and apply the famous motto "Dare quam accipere." Certainly you could say with truth "Dare quam doceri." The fact of the matter is that every Hospital has its own little varieties of method and that these will probably not be mentioned in the book. After a perusal of Dr. Buxton's work the student would hardly be fitted to administer an anæsthetic in the approved Guy's fashion. But this is not the fault of the book, which sets out the principles underlying the administration of anæsthetics with considerable lucidity, and every student would be the better for reading it. But it doesn't strike us as being particularly practical. From the practical point of view the section dealing with nitrous oxide is the best. All the various forms of apparatus in common use (and a good many for which you may search the cupboards at Guy's in vain) are explained and there is quite a valuable chapter on Complications and Accidents—a chapter that most students will turn to first of all.

The book is full and accurate though doubtless many anæsthetists will not agree with some of Dr. Buxton's conclusions. In all cases he sets down the prevailing views with great fairness, so much so in fact as to be somewhat embarrassing to the student who, naturally, prefers the dogmatic. One is left, for example, with rather a vague idea as to Dr. Buxton's own views as to the safety (or danger) of nitrous oxide and oxygen. He quotes the authorities, whose views are widely divergent, and leaves the reader to draw his own conclusion. Even the student will be able to do so when he comes to the practice of anæsthetics. At any rate the influence of the individual teacher on such matters will always be greater than all the books in the world. But for the physiological, pathological and pharmacological principles underlying anæsthesia we can confidently recommend Dr. Buxton's book to all students who feel the need of such a work.

Football.

GUY'S v. MIDDLESEX.

Semi-Final Inter-Hospital Senior Cup.

As neither Charing Cross nor King's competed this year, we found ourselves in the Semi-Final without having played a game. One hopes both for the sake of the Competition, which has ever been a popular one, as well as for the sake of Hospital Rugby Football that another year will see all the old competitors with a team to compete.

Middlesex were beaten by a big margin, 10 goals 6 tries to 1 try, 68 points to 3. The game was not very old before Van Zyl managed to get across from a line out, but previous to this the Guy's forwards had shown themselves very much on their mettle, though the Middlesex men while they remained fresh were by no means to be despised. We certainly had the advantage in weight and this tells enormously in these games. Van Schalkwijk with a good kick converted the try. Then Graham-Davies, Krige and Steyn got going, the last named scoring. Shelswell, who again played well, was the third scorer on the list, Neser's kick at goal failing. Then our backs put in some fine passing and running and Steyn, going well and getting right round, placed for Van Schalkwijk to goal easily. Later on Duncan scored behind the bar for the outside half to convert again. Graham-Davies just afterwards added another 3 points. Albertijn got one in before the interval and Graham-Davies who appeared in excellent form and who was played up to well by J. A. Krige helped himself to another try. At half-time we had accumulated 34 points.

A wonderful kick of Daneel's right from the touch-line converted into a goal a try in the corner which Albertijn scored. J. A. Krige and Graham-Davies were the next, in the order given, to go over the Middlesex line, Van Schalkwijk doing the needful. Albertijn and Steyn following soon after with a try a-piece followed in the latter case by a successful kick from Van Schalkwijk. Before the end we managed to get another brace of goals, one by Van Schalkwijk from Graham-Davies' last try, and one, a really splendid kick, from a try obtained by Steyn. The try for Middlesex was secured by Muir. Though the opposing team were, without egotism, soon beaten as regards points, they never were as regards spirit. They lost their full back for some portion of the game and for some time owing to another injury played only 13 men. It is not difficult to try to buck up a fallen foe. In this case, however, it comes particularly easy, for the foe never gave in, but played as though the game was neck to neck right to the very end. May greater success and better luck be the just reward of so great an exhibition of splendid pluck. Result: Guy's 68 points, Middlesex 3.

Guy's Team.—A. Daneel, H. Graham-Davies, J. A. Krige, P. K. Albertijn, C. L. Steyn, J. Van Schalkwijk, F. Bekker, W. D. Doherty, R. F. H. Duncan, E. E. Neser, A. H. Shelswell, A. H. Van Zyl, W. H. Taylor, R. M. Macintosh, C. F. Morrison.

Hockey.

GUY'S v. UNIVERSITY COLLEGE HOSPITAL.

Semi-Final Inter-Hospital Cup.

Guy's qualified to meet St. Thomas's in the Final of the Hockey Cup by defeating University College Hospital on Tuesday, March 8th, by 6 goals to nil. Decisive as this victory certainly is, it must be borne in mind that our opponents were only a scratch team the majority of them being, we understand, Rugger enthusiasts. We fielded a team somewhat below strength, W. S. Hunt and C. G. Bowan having to stand down owing to injuries, their places being taken by J. E. H. Duckworth and S. C. Olver. It is expected, however, that a full team will be found playing in the final.

Guy's had all the best of the play, and it was only on rare occasions that their opponents looked like scoring, and but for a certain amount of bad luck, and some plucky saves by their goalkeeper, the score would most certainly have been even more in Guy's favour. Half-time found Guy's leading by 2 goals to nil. B. M. Tonkin having scored from a scramble in the circle while F. E. Graham-Bonalie added a further point by a good shot from a corner.

In the second half J. W. Schollum, who was always in the picture, scored once, Bonalie twice—

his last goal being a nice first time shot from a long pass, and H. Slater—who played an admirable game—scored from just inside the circle.

Other than those already mentioned L. E. Owen showed good form at outside left, K. Hooper was very steady and on the spot at centre-half, and Mackay was good at back.

Guy's Team.—C. V. T. Baugh, Mackay, H. F. Hurdle, S. C. Olver, K. Hooper, H. Slater, J. E. H. Duckworth, J. W. Schollum, B. M. Tonkin (Capt.), F. E. Graham-Bonalie and L. E. Owen.

Boxing.

The Inter-Hospital Boxing Competition was held on Tuesday, March 8th, at the National Sporting Club, the Cup coming to Guy's Hospital who scored 16 points (3 winners and 2 runners-up). St. Barts. and London each scored 8 points, St. Thomas's and Middlesex 4 points and University College Hospital 2 points.

Guy's entered a representative for each weight, seven in all.

The N.S.C. was well-filled, and a great deal of enthusiasm was shewn by the spectators, who cheered long and loudly both during the bouts and in the intervals. The judging and refereeing were in the hands of the A.B.A.

Bantam Weight.—M. T. Aung of Guy's received a bye in the first round in which Plum of Thomas's beat Askenza of Middlesex. In the semi-final Fernandez of London beat the Guy's representative, the latter did all the leading and must have lost by a very small margin of points. In the final Plum beat Fernandez.

Feather Weight.—The Guy's representative, J. D. Sanby Thomas, showed great form. He received a bye in the first round, in which Kotkin (Middlesex) beat E. W. C. Thomas (Barts.). In the semi-final, J. D. S. Thomas beat Kotkin, the referee stopping the bout in the third round. The final, between the Guy's man and T. A. Butcher (U.C.H.) was a great exhibition of pluck and determination. The U.C.H. man was beaten from the start, but not once did his efforts slacken, and even at the end of the third round Thomas received a jarring right which gave him a deal to think about. The verdict eventually went to the Guy's man, on points.

Light Weight.—Semi-final. T. A. Shaw of Guy's beat Arundel (Middlesex). Shaw showed quite good form, using a plodding left to great advantage, colouring his opponent, and winning well on points. Meeting C. Thomas (London) in the final, he adopted much the same tactics, but Thomas developed a habit of slipping and receiving Shaw with his left shoulder. Shaw won on points.

Welter Weight.—T. N. O'Rafferty of Guy's received a bye in the first round. Meeting Vaughan Jones (London) in the semi-final, Rafferty was beaten on points after a gruelling bout in which both showed much weakening.

Marcuse (Barts.) won the final.

Middle Weights.—T. G. Rossdale of Barts. beat Freehran of St. Thomas's. Rossdale was much too fast and clever for his opponent, and the towel came in from the latter's corner in the second round. The final, between Fripp of Guy's and Rossdale, was over even quicker, the referee stopping the bout in the first round.

Light Heavyweight.—Final. Barker (Middlesex) beat W. H. Summerskill of Guy's. The latter held the advantage to the middle of the second round, when he received a shaking blow which put him at the mercy of his opponent, the referee stopping the bout after the Guy's man had been sent down rather heavily.

Heavy Weight.—Kennedy (London) beat Guilfoyle (Barts.) after a punishing bout in which neither paid attention to defence. Guilfoyle weakened in the third round and the referee applied the closure. Final.—J. A. E. Dennysen of Guy's met Kennedy in the final. The former with his extremely orthodox straight left, and his "wait and see" tactics, completely puzzled his opponent, and gained the verdict on points.

The success of our team was largely due to the efforts of our instructor, Mr. Alf. Hewitt. We cannot conclude without a word of congratulation to him, on the excellent results of his teaching.

Birth.

SHERRIS.—On March 8th at 112, Military Road, Colchester, to Dorothy, wife of Dr. Cyril Sherris, a son.

Marriage.

GWYN-DAVIES—GREENWOOD.—On the 28th Feb., at Holy Trinity Church, Folkestone, W. L. Gwyn-Davies to Elvira, only daughter of W. Greenwood, Barrister-at-Law, Folkestone.

Death.

GATLEY.—On 28th February, at Mill Vale House, Bratton, Westbury, Charles Alexander Robertson Gatley, M.R.C.S., L.R.C.P., aged 31.

Ed.—M. E. S.

GUY'S HOSPITAL GAZETTE.

VOL. XXXV., No. 854.] APRIL 2, 1921. [NINEPENCE.

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Passim.

THE decision of the War Memorial Committee which we published as "final" in the last issue of the GAZETTE has raised a storm of criticism and opposition culminating in a gigantic appeal, with many hundreds of signatories, to protest against the proposed wording of the inscription. The Committee were no doubt aware that any decision they might make would not be accepted without arousing some degree of opposition amongst the very large numbers concerned. But the protest in this case has been almost startling in the swiftness and unanimity with which it has descended, and the Committee must perforce take notice. An excellent letter from Dr. Ryle on page 136, sets forth the reasons which have led to the protest. Similar situations have arisen in connection with other War Memorials but the result desired by the signatories of this protest has usually been secured by the action of the younger members of the Committee concerned, and it was perhaps a pity that the meeting was so small at which the decision, in this case, was made, and that those members of the Hospital who had actually fought in the war were so poorly represented.

As Dr. Ryle points out, the memorial is here to commemorate the dead and not the living, and therefore the words "To the honour of those who came through," especially as they are placed first before any mention had been made of the dead, are singularly inappropriate. Those who came through are, many of them, here at the Hospital now and have no wish for a memorial of any sort and certainly not for one which should be sacred to those who gave their lives. The words in question were suggested by a contributor to the GAZETTE some months back and as it was greeted with silence we think that the Committee can hardly be blamed for selecting words which seemed to have secured the tacit approval of our readers. It is a pity that every one of those who have now at the eleventh hour expressed their disapproval allowed the suggestion to pass unchallenged when it first appeared in the GAZETTE. We have heard it said, nor have we ventured to disagree, that no suggestions made in the GAZETTE are ever adopted. True as this may be in a large number of instances here is a case to the contrary and we think that those who might have directed the minds of the Committee are largely to blame in not making their criticisms earlier. Dr. Ryle says that the inscription is unthinkable. We are inclined to agree with him in this, as in the arguments he puts forward as to why it is unthinkable. But Dr. Ryle and his co-signatories have had this suggestion before them for many weeks (if they read the GAZETTE).

If the letter had appeared before the last meeting of the War Memorial Committee we have little doubt that its members would have been influenced by its admirable common sense, for it certainly expresses the views of all those who "came through." As it is the Committee must, we think, reconsider the wording of the inscription; but their critics who have been so enthusiastic in their belated attack on the Committee's decision have not been helpful with suggestions for an alternative, and so the Committee are exactly where they were. They know, to a limited extent, what is not wanted. We hope that in our next issue some at any rate of the many hundreds who have protested will give their views on a suitable inscription to take the place of the one they are so eager to condemn.

Personally we think the less said the better The Memorial, with the dates on, will always be a sufficient indication of its purpose. The dates of the war will remain in the memory of Englishmen as long, if not longer, than the historic dates of Hastings, Trafalgar and Waterloo. If words must be added we doubt if anything better could be found than the simple quotation "Their name liveth for evermore." All the previous suggestions have seemed to us to be rather lacking in poetry. We have made the arch as beautiful as possible. The words should surely be no less beautiful. Nothing at all is far better than the mediocre.

Mr. Ormond tells us that he has undertaken the heroic task of acting as Secretary to the Biennial Dinner which again becomes due this year. How heroic he is will probably become more and more apparent to him as the time draws nearer. Past Secretaries will, at any rate, appreciate the vast amount of work entailed in this arduous post, and all will agree that he will accomplish it with his usual skill and tact. He asks us to make it known that the Dinner will be held on Wednesday, October 26th, and that it will take place, as usual, in the Connaught Rooms. The Committee have asked Mr. Montague Hopson to be President. We are sure that all Guy's men will welcome this early intimation of the date, and that as many as possible will keep the evening free and thus ensure for this year's Biennial Dinner the success that these functions have always met with in the past.

In the last number of the Gazette it was our pleasant duty to welcome back to the Hospital the cups for the two inter-hospital football events. Since then two cups which have had their resting place in the College Smoking Room for the past year have departed for a season (we hope for no longer), and a third has had a day's outing and is now safely back in its right and proper place. The University of London Association Football Cup was lost to King's College after a hard fought game in which Guy's did all the pressing in the second half. Although the score was only 2–1 the victory went to the better side to the great satisfaction of seven 'bus loads of King's enthusiasts who turned up in fancy dress, with a band, and added greatly to the entertainment of quite a large number of the general public which found its way into the Arsenal Ground that afternoon.

In the junior inter-hospital association cup our "A" team was defeated by 3–2 while the "A" rugger xv. successfully accounted for Barts.'. In addition to these events we lost the inter-hospital hockey event to St. Thomas' by 5–0. There still remain the cricket, tennis, rowing and swimming cups to be competed for during the summer. Good luck to the respective clubs in these events!

The subject of cups reminds us that many months ago we drew attention to the inadequacy

of the glass case in which these trophies are at present contained. It is an inadequacy of position rather than capacity, though this latter may have to be increased if our athletes are so consistently successful as they have been since the war. It really is a great pity that such a magnificent array of cups should be hidden away in a room so little frequented as the smoking room. Hardly anyone goes into it except at lunch time and no visitor or member of the staff ever enters. Surely a better place could be found. The dining room or the Wills Library both suggest themselves. We hope that the Clubs' Union Council will consider the matter seriously. Everyone seems agreed that the present place is an unsuitable one but nothing is done to improve upon it. It should not be difficult to find a good alternative.

An interesting revival during the past fortnight has been that of the contest for the Inter-Firm Tug-of-War Cup presented by Mr. Clement Lucas in 1899. Queen Victoria were the holders, and the Rowlands firm challenged them. The challenge was accepted, and enthusiastic scenes were witnessed in the Park when the contest took place before a large crowd of spectators. The pulling was more vigorous than scientific, and resulted in a win for the obstetric firm in the best out of three pulls. Mr. McNair very ably coached the winning team with a flow of highly technical language which seemed to be intelligible to the men at the rope. At any rate they won their two pulls, but not without a struggle as the surgical firm made the contest go to its full length by securing the second pull.

Sister Alice presented the Cup at the conclusion of the contest, and was presented with a box of chocolates by a small patient from Dorcas amid enthusiastic applause. We hope that the custom of competing for this cup now it has been once more so successfully revived will not be allowed to die out. We understand that the winning team are ready to meet all comers, and we trust that a challenge will shortly be forthcoming.

Guy's Hospital Missionary Society.

Receipts and Payments for the year ended December 31st, 1920.

1920.	Receipts.				
To balance brought forward:—					
	Cash at Bank	23	10	10	
	Petty Cash in hand ...	0	2	0	
					23 12 10
„	Subscriptions and Donations				25 16 8
					£49 9 6

1920.	Payments.				
By	Subscriptions to other Funds	16	16	0	
	Printing, Stationery, Magazines, &c.	2	7	8	
	Postages	0	5	8	
					19 9 4
	Balance carried forward:—				
	Cash at Bank	29	4	10	
	Petty Cash in hand ...	0	15	4	
					30 0 2
					£49 9 6

Audited and found correct,
W. J. CURRY.
January 26th, 1921.

Specialities.

Messrs. H. Whiteway & Co., Pomona House, 37, Albert Embankment, S.E. 11.

Pure fermented juice of the apple is recognised in Dietetics as being of service in cases of Gout and Rheumatism, and people suffering from these complaints can have no better brand of Cider than the "Woodbine", made by Messrs. Whiteway & Co, who have long been noted for the excellence of their manufactures

Made from the pick of the apples from their extensive orchards in Devonshire, and prepared under the most favourable conditions, "Woodbine" Cider will be found both palatable and effective.

Messrs. H. Whiteway & Co., will be pleased to send a sample to Medical Men on application.

Cases of Gall-Stones.

CLINICAL LECTURE BY Mr. F. J. STEWARD.

Gentlemen,—I propose to tell you about some cases of gall-stones which I think illustrate very well some of the most important clinical features of the disease.

A woman, aged 53, who had previously been free from abdominal trouble, was admitted for acute abdominal symptoms that had begun quite suddenly two days previously with intense pain, shivering and vomiting. The woman looked ill, and had a temperature of 103°, and pulse 110.

On examination, the upper part of the abdomen was rigid and tender, especially on the right side, where a distinct tender swelling having the characters of a distended gall-bladder could be made out. I diagnosed acute cholecystitis, and operated forthwith. On exposing the swelling it proved to be a tense, deeply congested gall-bladder with some recent lymph on the surface. The gall-bladder was opened after being isolated with gauze packs, and was found to contain a mixture of pus and bile and three large gall-stones, which were removed. Further examination revealed another large stone firmly fixed in the neck of the gall-bladder. This was removed, a tube stitched into the gall-bladder and the rest of the wound closed. The patient made a rapid recovery.

What can we learn from a consideration of the facts of this case? First of all, we learn that stones may lie in the gall-bladder for some considerable time and give rise to no sign of trouble. I say *for some considerable time*, because in this particular case the stones were as big as the end of my index finger; and, of course, they could not have formed in a night.

The next thing we learn is this: that a stone that has been lying, we might say, dormant in the gall-bladder may suddenly, through perhaps spasmodic contraction, become lodged in the neck of the bladder and there fixed.

The third point is, that impaction of a stone in the neck of the gall-bladder may be followed by an attack of acute cholecystitis. For when the gall-bladder was exposed, you will remember, it was deeply congested, thickened and swollen, and there was lymph over the surface. Further, the obstruction to the neck of the gall-bladder was followed by distension of that organ.

Also we learn what symptoms are produced by the lodgment of a stone suddenly in the neck of the gall-bladder. You will notice that they are the symptoms which are commonly grouped under the heading of the "acute abdomen" For instance they are not unlike the symptoms of an acute attack of appendicitis. The patient is seized with sudden pain in the abdomen, associated with violent vomiting, and, in this case, with shivering. We find that after two days she looks ill, has a rise of temperature and pulse, and the abdomen is rigid and tender. All that would do for an acute attack of appendicitis. Moreover the tenderness and rigidity and pain are on the right side of the abdomen. So that we learn that the symptoms like those of acute appendicitis may be produced by the impaction of a stone in the neck of the gall-bladder.

Further, we know from this case that these are the symptoms and signs produced by acute cholecystitis. As regards further examination we know that this condition gives rise to an enlarged gall-bladder which could be felt in this case, and that the enlarged gall-bladder is extremely tender.

Also we learn what the treatment is. An operation was done, the gall-bladder was opened and emptied, the stones were removed; a stone was removed also from the neck of the gall-bladder; and the patient from that time did quite well.

Suppose, on the other hand, that an operation had not been performed, the question arises as to what might have happened. In the first place, the stone might have dropped back into the gall-bladder, the condition being immediately relieved. Secondly, if the stone remains *in situ*, empyema of the gall-bladder will probably result. The cholecystitis goes on, the gall-bladder becomes full of pus, and may become perforated, the gall-stone escaping into an abscess cavity outside the gall-bladder. We know, further, that such an abscess may open into various parts, as, for instance, into the small bowel, and in this case, as you know, the stone may give rise to one form of acute intestinal obstruction. Stones may similarly pass into the large bowel and be passed per anum. Or a sub-diaphragmatic abscess may form and, under these circumstances, stones have even perforated

the diaphragm, subsequently being removed from the pleura. Moreover, the abscess may track about in various directions in the abdomen, and may even open spontaneously at the umbilicus, and, in fact, stones have been passed from the umbilicus, and a biliary fistula formed there.

But when a gall-stone becomes impacted in the cystic duct, that occurrence is not by any means always followed by the acute symptoms that were present in the case I have described.

Case 2 illustrates this, the case of Mrs. G.—, whom I saw, first of all, on December 3rd last year. The history was as follows:—

Every few months since 1917 she had had attacks of acute pain lasting several hours, accompanied by much retching, and then passing off. Afterwards she was sore for a day or two. Her doctor, Dr. Brockwell, examined her during two attacks, and felt a tense, tender, enlarged gall-bladder. I operated upon her on January 3rd this year, just after a further attack, the gall-bladder being enlarged and tender, and I found the gall-bladder thickened and distended, and a single stone in the neck of the gall-bladder, which I removed. The gall-bladder was then drained, and the patient made a rapid recovery. Here then is another case in which impaction of a stone in the neck of the gall-bladder, was followed by attacks of pain, and distension and tenderness of the gall-bladder. But in this case all the symptoms passed off spontaneously and were never nearly so serious as in the first case.

The explanation of the difference between these two cases will, I think, be simplified if I describe another case to you.

Case No. 3. Mr. M——, aged 62. I saw in consultation on Nov. 17, 1920. He had always been an extremely healthy man and had never had any serious illnesses, but for the last year he considered that he had been failing in health, and for three months he had had some pain in his lumbar region. Moreover, he had lost one stone in weight. There was, therefore, nothing very definite about the history. On examination, a well marked tumour was felt in the position of the gall-bladder. It projected three inches below the edge of the liver, and had a rounded lower edge, and was not a bit tender. Here then the gall-bladder was very considerably enlarged and distended, but the patient had had nothing to be compared with the attacks of pain in the previous two cases that I have told you about. This patient was operated upon on December 2nd, 1920, and on exposing the swelling it proved to be what we thought it was—an enlarged, distended gall-bladder. But the wall of the gall-bladder was quite thin, and the peritoneum quite smooth and shiny; there was not the slightest sign of inflammation about it at all. On opening it I found a large quantity of clear mucus and three large gall-stones about as big as the end of my thumb, one of them impacted tightly in the neck of the gall-bladder. The case was then one of distended gall-bladder, what is termed mucocele of the gall-bladder, the result of the impaction of a stone in the neck of the gall-bladder. But the patient, unlike the previous two, was not even conscious of the time when the stone became impacted. He had no pain or tenderness, excepting some slight pain in the lumbar region. Further, when the gall-bladder was exposed there was no sign of inflammation about it. To compare the three cases. In the first case the impaction was associated with extremely severe cholecystitis and with extremely severe symptoms. In the second case both the cholecystitis and the symptoms were much less marked. In the third there is no evidence of cholecystitis, and the patient was quite unconscious of the impaction of the stone. So that I think we may fairly conclude, from the study of these three cases, that, in the first place, not only may a stone, when it becomes impacted in the neck of the gall-bladder, set up extremely acute symptoms; but that equally, if there is no infection of the gall-bladder impaction of a stone may be associated with practically no symptoms at all. It is then the *infection* which determines the severity of the symptoms and not the *obstruction*. There is nothing unusual about this, the reverse in fact, for similarly the frontal sinus may become greatly increased in size and distended with mucus almost painlessly, but obstruction associated with infection is accompanied by extremely severe symptoms, pain in particular. The same may be said of the appendix, the kidney and the fallopian tube. Sometimes, a mucocele of the gall-bladder caused by the impaction of a stone in the neck of the gall-bladder, will give rise to a tumour of quite an extraordinary size. In one case the tumour was mistaken for an ovarian cyst, in another the mucocele extended down the right side of the abdomen, and a portion of it passed through the femoral ring and produced a femoral hernia.

We now pass on to the consideration of a different type of case. The next patient, had for 25 years at intervals suffered from abdominal attacks. The attacks consisted of very severe pain which commenced quite suddenly and doubled her up. The pain was located in the upper part of the abdomen and passed through to the back and also up to the right shoulder. The pain lasted usually several hours and up to 24 hours, and left her very sore in the region of her gall-bladder for some time afterwards. Moreover, these attacks were usually followed by jaundice which lasted a few days, up to a week. The attacks had in the early years been infrequent, but latterly they had become much more frequent and more severe; so that, although she had always been much against the idea of any operation being performed, at last her life became such a misery to her from the constant repetition of these attacks that she was forced to it. I was asked to operate on her. I cut down on the gall-bladder, and I found it filled with little facetted calculi; there were between 80 and 90 in number, and they were roughly about the size of a pea.

What does this case teach in connection with gall-stones? In the first place, that the gall-bladder may contain an enormous number of gall-stones, and that the patient may go on for many years suffering from the attacks of pain in the upper abdomen, which we call biliary colic.

What is the difference between this case and those I have already described? You will notice that there is one great difference. In this latter case the attacks were associated with jaundice. This jaundice is due to obstruction to the flow of the bile into the duodenum, which must have been produced by a stone passing into the common duct and blocking it for a time.

We might naturally ask, why is it that in one case a stone becomes impacted in the neck of the gall-bladder giving rise to acute cholecystitis; and in another case the stone passes into the common duct and causes obstructive jaundice and eventually escapes into the duodenum? The answer is quite simple. It is purely a matter of size. In the first case that I described the stones were all big ones, and they physically could not pass along the cystic duct and into and along the common bile duct. On the other hand, in this last case, the stones were very much smaller, as I have told you, and in consequence of that fact they were swept rapidly from the gall-bladder along the cystic duct into the common bile duct and so into the duodenum. That is the explanation of the different symptoms produced by different sizes of gall-stones. But sometimes the stones are so small that as a matter of fact they do not give rise in their passage to a sufficient damming back of the bile to cause any jaundice; and these may be very difficult cases to diagnose.

One such case I will mention briefly, that of a lady whom I saw some years ago. She had had very frequent attacks of sudden acute pain in the upper abdomen. Sometimes the attacks lasted only ten minutes or a quarter of an hour, and then as suddenly passed off. Nobody could make out what these attacks were due to. In fact, the patient was thought to be neurotic—a very easy conclusion to come to. She went to see Sir William Hale-White, and he suspected the possibility of gall-stones. He told her to carefully investigate the fæces always after these attacks. The result was that in a week or so two tiny stones with facets on them were found. Then, of course, the diagnosis was certain. I operated on her and removed some 300 tiny facetted stones from the gall-bladder. So that in that case the stones were so small that they were rushed through the common bile duct into the duodenum so quickly that there was no time to produce any obstruction to the flow of bile, and therefore no jaundice was produced.

If the stone is rather bigger, between the size that goes through in a few hours and the size that cannot get through at all, it becomes impacted in the common bile duct. The result of that is complete obstruction to the flow of bile, and obstructive jaundice. The stone, moreover, may remain impacted for a considerable time, perhaps even for several weeks, and then it either passes through into the duodenum, or it appears to pass through. I use that word purposely. I say it either passes through, or it appears to pass through. By that I mean this: that the pain goes, the general discomfort and malaise associated with this condition go, and the jaundice gradually disappears; so that the conclusion is reached that the stone has passed through, when suddenly the pain and jaundice recur.

What happens in a case of this kind is this: Partly owing to the pressure inside the duct, and partly owing to the inflammatory changes set up in the walls of the duct, it becomes dilated. In consequence of the dilatation the

stone floats off into the dilated duct. The result, as you can see at once, will be that the stone *appears* to have passed, the bile can get through, and the patient feels better and seems to be going on quite well. Then quite suddenly the stone is washed down again and blocks the duct once more. That may go on indefinitely even for years, and is the condition spoken of as ball-valve stone.

Here is an instance. Mrs. W ——, was sent to me on October 27th, 1920. She gave this history. She had had attacks of pain, roughly, once a month for about twenty years, always associated with jaundice. They lasted three to six hours. The jaundice lasted two to seven days. So far you would think she had got a number of stones in the gall-bladder which kept on passing through into the duodenum. In February, 1918, she was operated upon by another surgeon, and no gall-stones were found. After the operation she said she was better for a time, and for a year she had no serious attack. Then the attacks began again. She was having them every month, and latterly the pain was getting worse and the jaundice lasted longer. Feeling that she must have a ball-valve stone, I advised a second operation. She took some time to think over whether she would be operated upon, and during that time she got worse and worse, and for the last three or four weeks she had continual jaundice. I operated upon her on January 3rd this year. I opened her abdomen and found, as you might expect, a good many adhesions. On examining her bile ducts I found the common duct so dilated that I could easily get my finger inside it. Clearly it was a duct dilated owing to the presence of a ball-valve stone.

After a rather prolonged search I felt a stone high up in the left hepatic duct, and after considerable difficulties I removed it. I had to incise the hepatic duct in order to do that. After a rather slow convalescence she got well and entirely free of her jaundice, and now she is better than she has been since she can remember. I strongly suspect that at the first operation in this case the common duct was not examined, or it would have been found to be dilated.

If an operation is being done for gall-stones, the ducts should always be examined although there is no jaundice at the time, and if you find that the common duct is dilated, a very careful search must be made for floating stones for one or more are almost certainly present.

I am only going to tell you about one other case. As a rule, if a gall-stone becomes impacted in the cystic duct, the gall-bladder becomes dilated. On the other hand, if stones pass through into the common duct and give rise to jaundice, the gall-bladder does not become dilated but tends to become shrunken, so that when you have got jaundice due to gall-stones, as a rule you cannotfeel a distended gall-bladder.

Moreover, if in a patient who has jaundice you do find a distended gall-bladder, it is usually a sign not of gall-stones, but of something else, such as, a growth in the pancreas, or a growth in the duct, or the papilla, or perhaps chronic pancreatitis. In other words, jaundice plus an enlarged gall-bladder is usually due to growth.

There are, however, exceptions to that general rule, and we have one here. This is a patient, aged 33, who was admitted to Hospital on December 15th last. The following report is by Mr. Harvey. About ten weeks ago the patient had been out, and during the night had had severe pain in the right side, lasting about an hour, and this was relieved by hot flannels. The next night the patient had pain in the side again, and flannels again relieved her. A couple of days after this patient turned very yellow. Since her first two attacks of pain she had had no recurrence, and had also been losing her yellow colour.

She was admitted after a further attack, and at that time she was slightly jaundiced. On examining the abdomen a tender area was noticed on the right side near the costal margin and a tumour could be felt at about the tip of the ninth rib, extending about one and a half inches downwards. In fact, this swelling was a typical gall-bladder tumour. After she came in her jaundice became rather worse and she had an attack of pain. So I felt inclined to delay before operating on her. She however got no better, and on January 4th I operated. The gall-bladder, the cystic duct and the common duct were found to be very much dilated. The gall-bladder was punctured, and a large quantity of green stained fluid issued from it, and a number of stones were extracted. Stones could also be felt in the common duct. This was therefore opened and three stones were extracted. An attempt was made to pass a probe down into the duodenum, but it was not successful. The incision in the duct was now closed and a drainage tube placed in the gall-bladder. The patient eventually recovered completely. Here is a case, then, in which attacks of pain

with jaundice were associated with an enlarged gall-bladder, proved at the operation to be due to gall-stones, and not to a growth of the pancreas or of the bile duct. So that we can say that although it is usually the case, if the gall-bladder is distended and there is obstructive jaundice, that the condition is due to growth, yet one cannot be certain that such is the case. Consequently, unless other features of the case make the diagnosis clear, it is important that the patient should be explored before a definite diagnosis of malignant disease is made.

I will only keep you a minute or two longer. I want now just to say one word concerning a subject which is much discussed at the present time, and that is, Radiography of Gall-stones. A few years ago it was said that gall-stones could not be demonstrated by X-rays. Now with improved technique the reverse has been proved to be true. For instance, in one published collection of seventy-seven cases examined for gall-stones there were thirty-nine positive results, and of these twenty-one cases were operated on gall-stones being found in twenty of them. So that of twenty-one cases in which the radiologist had given a positive diagnosis of gall-stone, in twenty of them gall-stones were found at the operation.

On the other hand it is certainly true that in a large number of cases in which gall-stones are found by operation, X-ray examination previously has failed to demonstrate them. So that in the first place, one may say that X-rays at present will not demonstrate gall-stones in every case in which they are present; but in a certain proportion of cases they come out very clearly and distinctly on the plate. Finally, in a certain number of cases the plate, apparently, shows gall-stones when operation fails to discover them. I think that about represents the position at the present time.

A number of radiographs, kindly lent by Mr. Coldwell, were then shown. In all of them gall-stones were very clearly seen, and in each of the cases the presence of gall-stones had been proved by operation.

Appointments.

Stanley Wickenden, M.R.C.S. Eng., has been appointed Assistant Visiting Surgeon to the Royal Infirmary for the City and County of Perth, N.B.

Obituary.

Charles Gatley.

The death of Charles Gatley will have brought great sorrow to the hearts of all of his friends and contemporaries, for in his year there were none more generally beloved and respected than himself. The sense of loss is particularly great when a man of such outstanding kindliness, cheerfulness and charm of personality is taken from us in the very best years of his manhood, and in his case there is an additional sense of misfortune for those who know, as most of us do, of the good fight back to health which he had made after serious wounds received while serving as a regimental M.O. in France, followed by much and painful sickness. At one time he was reported killed, but we were rejoiced to learn later that he was only wounded, though the wound was a very grave one. When last the writer saw him recovered from his injuries, but, after a period of fitness, again out of health, he was still apparently quite unaltered in his genial outlook, and his smile had the same particular charm and frankness that we used to know and love before the war. Physically well made and blessed with an honest, open and Saxon type of beauty, he had an attraction for all, and his character wholly befitted his appearance. In harness and out of harness, as student and resident, he was one of the very best of his period; an eager and steady worker with much common sense and sound judgment and a great fund of humanity. We know that in general practice he must have maintained the same high standards which were his as a house-officer, and that his profession and his patients have lost a man of great promise, and a valuable friend. Those of us who had the good fortune to know him well can picture clearly to ourselves his work in France. He was of the type that makes the finest Regimental Medical Officer, and than that there is no higher praise.

After much suffering he has won the great peace, and we can only hope that that thought will bring a little comfort to those who loved him most of all.

Change of Address.

Dr. W. P. Le Feuvre, Royal Hotel, Knysna, South Africa.

J. Saxon Davies, Hazeldene, Neath, South Wales.

Guy's and its Dental Surgeons.

By FRANK J. PEARCE, L.D.S.Eng., D.D.S.Penn.

(*Continued.*)

Thomas Bell: The next dental surgeon appointed to Guy's, Thomas Bell, was also a great man; in fact, one of the most scientific men of that time. He was born at Poole on October 11, 1792, the only son of Thomas Bell, surgeon. In 1813, he entered Guy's and St. Thomas's as a student, and I think we must conclude that he served an apprenticeship before then, as he became a member of the Royal College of Surgeons two years later, that is in 1815, the year John Keats the poet entered Guy's as a student.

According to the "National Biography," Thomas Bell was appointed Dental Surgeon to Guy's in 1817, though Wilkes and Bettany give the date as 1825. It is unfortunate that the hospital records do not assist us here—probably because at that time there was a very autocratic Treasurer named Harrison, known as "King Harrison," and it is said of him that he appointed members of the staff without consulting the other authorities. Bell remained on the staff until 1861. In 1829 he published his well-known work in two parts: Part I., "The Anatomy and Physiology of the Teeth"; Part II., "The Diseases of the Teeth." He states that Fox was the first to attempt to assign definite terms to the diseases of the teeth, and acknowledges that Fox's was the first scientific book on dentistry. He lectured on Structure and Diseases of the Teeth at the hospital, and in an announcement of the course of lectures for the session 1841—1842 it is stated that one or more courses will be given, and that the fee for each pupil is £2 2s., but that pupils entering to the anatomical lectures will be admitted to these lectures gratuitously. Bell was early attracted to natural history, more especially to zoology, and for some years he lectured at Guy's on Comparative Anatomy, and in 1836 he was appointed Professor of Zoology at King's College, London. In 1837 he published the first edition of his "History of British Quadrupeds," and this is stated to have been written in an easy and attractive style, and in spite of serious defects became very popular. In 1839 this was followed by "History of British Reptilia," and in 1853 by "History of British Stalk-eyed Crustacea." A second edition of "British Quadrupeds" was revised and partly re-written, assisted by R. F. Tomes, and this became a standard work. Bell was elected a Fellow of the Royal Society in 1828, and became one of the Secretaries of the Society from 1848 to 1853. He was one of the originators of the Scientific Meetings of the Zoological Society, and for eleven years one of its vice-presidents. He was President of the Linnean Society from 1853 to 1861, and under his guidance the society flourished, and it is stated that it is largely due to him that the society became located in Burlington House, as the Government was originally strongly opposed to this course. Whilst President of the Linnæan Society, Bell presided over the meeting on July 1, 1858, at which the Darwin and Wallace papers on the "Origin of Species" were read. Salter, who later on became Dental Surgeon to Guy's, was present at that meeting and signed the roll.

Bell was President of the Ray Society from its foundation in 1843 until 1859. He was also, I think, President of the Microscopical Society. He practised at 17, New Broad Street, and at the age of nearly 70 retired from practice, and purchased from the grand-nieces of Gilbert White, the naturalist, "The Wakes," Selborne. Here he collected relics and memorials of Gilbert White, and in 1877 he produced his classic edition of Gilbert White's "Natural History of Selborne," with a Memorial to Gilbert White. This was written in his most pleasing style. It is recorded that Bell's manners were most attractive, gaining for him the confidence of the young and old of all classes. His remarkable memory, stored with varied information, remained intact almost to the close of his life in 1880 in his eighty-eighth year.

Richard Owen published his "Odontography" between 1840 and 1845, and he dedicates it to Thomas Bell in the following letter, dated 1845: "My dear Bell,—Independently of the pleasure with which I embrace this opportunity of expressing the feelings of Friendship and Esteem which I have long entertained towards you, there is no one to whom the present work could with more propriety be dedicated than the acute observer who was the first to point out Pathological Phenomena in the Human Teeth, consistent only with a higher organization and mode of development than it has been usual to attribute to them, but which it is the chief object of the following pages to demonstrate as common to the teeth of all Vertebrate Animals. I am, yours very sincerely, Richard Owen."

Owen's work was in reality the substance of the lectures on Comparative Anatomy and Physiology of the Teeth, which formed part of the Hunterian courses delivered at the Royal College of Surgeons in 1837, 1838, and 1839. Thomas Bell was one of the first examiners for L.D.S. in 1860, John Tomes and Arnold Rogers being the others.

Both Fox and Bell left their collections to the Guy's Hospital Museum, and many of them can there be examined, but it is to be regretted that the collections of these famous men were not kept separate from the general specimens. I think that many of them were so arranged in the old Anatomical

Museum when I was a student—that was, of course, before the Gordon Museum was built.

Samuel James Augustus Salter was Dental Surgeon to the hospital from 1851 to 1880; part of that time, from 1851 to 1861, he was associated on the staff as Assistant Dental Surgeon to Thomas Bell.

James Salter, as he always called himself, came from a medical family at Poole, and was born in 1825, the year of the institution of the Guy's Medical School. He received most of his medical education at King's College; he took his M.B. at London University in 1849, and the M.R.C.S. and L.S.A. in 1847; was House Surgeon at King's College, acting in that capacity to the celebrated Fergusson. His uncle, Thomas Bell, induced him to specialize in dentistry, and he eventually joined him in practice. In spite of a busy practice, he found time to interest himself in scientific matters, and was an active member of several societies. He was the author of a paper read before the Philosophical Society on the "Structure of the Tooth of Echinæ," and in 1863 became a Fellow of the Royal Society; he was at this time already a Fellow of the Linnæan Society. In 1874 he published his work on "Dental Pathology and Surgery." This book did not pretend to be a complete treatise on the subject, but was probably really an elaboration of the lectures which he delivered at Guy's, together with many original and thoughtful observations, and it is even to this day a book which is well worth referring to. Salter was, in addition, a good botanist, and several papers of his are recorded in the *Linnæan Society's Transactions*, some of which contain original discoveries. On retiring from practice he went to live in the country, and occupied himself with farming and other rural pursuits, possibly with hunting, as he had been a very regular member of the Meet, even whilst in practice. In addition to these pursuits, he is said to have amused himself with the study of heraldry and archæology. He seems to have been a most amiable man and a delightful companion. He married late in life, but his wife predeceased him by a year or two. He died in March, 1897.

There are many papers written by him in the *Guy's Hospital Reports*. In the volume for 1852, there is a paper on dentine of repair and the laws which govern its formation, illustrated by two plates. In the volume for 1855, there is another on the intrinsic calcification of the permanent tooth pulp, constantly associated with dental surgery as distinct from dentine of repair. In the volume for 1856, there is an account of a large myeloid epulis in the lower jaw, and in 1858, there are further contributions to dental pathology on the shedding of the teeth and exfoliation of the alveolar process consequent upon eruptive fevers, on warty teeth, and on polypus of the tooth pulp; in the volume of 1860, a case of ovarian tumour containing teeth, hair, &c.; in the volume of 1866, on teeth as passive organs of speech, and several others.

As I have said, he practised with Thomas Bell at 17, New Broad Street, and he also acted as examiner in dental surgery at the Royal College of Surgeons. The founder of our dental School, Mr. Newland-Pedley, was examined by him. It has been said of Salter that had he confined his talents purely to the study of scientific matters, he would have made a great name in science.

Henry Moon: Assistant dental surgeon from 1870 to 1880, and full dental surgeon from 1880 to 1887. Henry Moon was the son of William Moon, a doctor in practice at Tottenham. He was always of rather delicate health, and Dr. Braxton Hicks advised him to take his medical qualification with a view to specializing in dentistry. He came to Guy's as a medical student, took his L.S.A. in 1862, his M.R.C.S. in 1866, and then studied at the Dental Hospital, taking prizes there and his L.D.S. in 1867. He was appointed Assistant Dental Surgeon to Salter in 1870, and on Salter's retirement he was appointed dental surgeon and lecturer on dental surgery. He was in addition dental surgeon to the Dental Hospital.

He was author of a section on dental surgery in Bryant's "Practice of Surgery." In the *Guy's Hospital Reports* of 1873—1874 he writes on mechanical appliances for treatment of fractures of the jaw. In the *Transactions of the Odontological Society* there is a communication by him on a method of pivoting; he became a Vice-President of this Society.

His health, which was never good, failed, and he went to visit his brother in New Zealand, and while he was away his appointment was kept open for him, and it was during this time that Mr. Newland-Pedley did much of his earlier work at Guy's, practically acting as dental surgeon to the hospital. Moon returned to England, but died on November 14, 1892.

Dr. Braxton Hicks says of him that he was of a gentle and kindly nature, most conscientious and thoroughly reliable. This is borne out by a dear old lady patient of my own, who used to consult Moon. She always speaks of him as being very gentle and kind in all his dealings with her. Dr. Braxton Hicks refers to an incident of Moon's childhood. When he was seven years of age, he fell downstairs and nearly bit off his tongue in the middle, only about one-third remained unsevered. Dr. Hicks sutured the parts and the tongue healed rapidly and scarcely any mark remained. Both Salter and Moon in their work at Guy's used elevators for extracting teeth which bore their names, and I take it the large thick right angle probe,

which we use and know as Moon's probe, was also of his design.

I will now take you back to 1877: at that time Salter was senior dental surgeon and Moon was assistant. In the May of that year there entered Guy's as a medical student a man who was to entirely revolutionize the dental work of the hospital: Mr. F. Newland-Pedley, who was the son of a dentist practising at 12, George Street, Hanover Square. His father was forced by ill-health, however, to give up his practice in London in 1872, and went to Australia with his family. But it was destined that our founder should return to London, and this he did entering Guy's, as I have said, as a medical student in 1887. It was on Moon's advice that Mr. Newland-Pedley entered as a student at the Dental Hospital, and he spent his time between Leicester Square and Guy's, and it must have been, as he describes it, "a dog's life," especially in the summer when he had to attend lectures at 8 a.m. He soon became a useful assistant to Moon, and passed his L.D.S. in 1880, Salter being one of the examiners. He also passed his M.R.C.S. in 1881, and later his F.R.C.S. in 1885. Moon came to leave more and more of the work to Mr. Newland-Pedley and he soon became ashamed of doing nothing but extractions and began to undertake fillings, more particularly among the students. For a time he undertook various posts as locum tenens to doctors, but finally decided to stick to dentistry, and began reading for his Fellowship. During this time he did a good deal of coaching for men going up for the dental diploma from Leicester Square; he was as always a good teacher, and it is his proud boast that only two of his students were referred. He then started practice in Finsbury Square, close to Moon, who shortly after removed to 112, Harley Street.

He was appointed dental surgeon to Guy's in 1887. He had, however, started a campaign previous to this for the better dental treatment of patients attending general hospitals, and he tells me that it was in 1886 that he originated his project for our dental school. On his appointment to Guy's, he was brought into close touch with Dr. E. C. Perry, now Sir Cooper Perry, and they both of them worked very hard for the project of starting a dental school. In 1888, Mr. Newland-Pedley drafted his scheme for a dental school, whilst in the Louvre, Paris, and I hold the original draft in my hand at this moment, documents which I venture to think will be prized by Guy's dental men for ever.

This scheme was brought before a school meeting, and was well received, and in due course was adopted. It then went before the Governors and received their sanction on December 19, 1888, the object of the inauguration of the school being to increase the efficiency of the hospital as a charitable institution by providing the poor of the neighbourhood with the benefits of conservative dentistry, and to enable dental students to complete their education under the most favourable conditions; previously they had to attend a dental hospital in addition to attending the lectures and practice of the hospital.

The original buildings for the dental school comprised a conservation room (a term devised by Newland-Pedley)* and a dental laboratory.

The former was erected immediately behind the old Fives Court, which adjoined what was known as Petersham House. Its exact site was that of the women's waiting room in the present buildings. It was a lean-to room equipped with twelve wooden chairs, which admitted of a certain amount of movement, arranged in two tiers. A drawing of this room appeared in the *Daily Graphic* for October 1, 1890. I have a copy of it here and some of you may recognize the portraits of some of the students at work.

The dental laboratory was another small detached building facing the main windows of the conservation room. This meagre accommodation was soon overgrown, and early in 1891, the dental department was housed in Mary ward (now Stephen ward), whilst the present dental school buildings were being erected. Mr. Newland-Pedley tells me that, whilst they were putting in the foundations of the new school, they mixed quantities of extracted teeth in the cement, feeling that after all these had been the real foundation of the school, and not without hope that in years to come they might give antiquarians something to puzzle about.

I am happy to state that our Founder is still with us and in good health, and he must be a proud man to-day to know that his efforts have been so successful. We, of Guy's Dental School, feel that we owe more than we can ever repay to him for giving us the opportunity of studying for our profession at an institution with such a glorious past, and I can assure him of the honour and pride we feel in all the work he put in to give us this great heritage.

The original staff of the school comprised a dental surgeon, six assistant dental surgeons, and two anæsthetists. Their duties commenced on May 1, 1889, and the school was officially recognized by the General Medical Council on October 1 of that year.

We are a young school, but I think you will agree that we have reached a certain degree of

*I find that I was in error in ascribing to Mr. Newland-Pedley the distinction of devising the term "Conservation Room," this honour belongs to Mr. N. Davies-Colley. See Mr. Newland-Pedley's letter in *Guy's Gazette*, February 19th 1921.

maturity when I tell you that the first dental student to enrol at Guy's in January, 1889, is now our Senior Dental Surgeon, and a past President of the British Dental Association, Mr. Montagu F. Hopson.

I cannot leave this part of my subject without mentioning one of our institutions, the Guy's Hospital Dental Society. Founded in 1894, Mr. Newland-Pedley being the first President, this Society can already look back upon a very useful past, and I believe that it is to our students' societies that we must look for the future success of our Association, as it is in these societies that men should learn to take part in work for the common good of our profession.

Now, having outlined the history of our school, I trust that I have not wearied you, and that I have not laid myself open to a similar reproof to that administered by the Editor of the *Lancet* in 1862, who, in reviewing the *Guy's Hospital Reports* of that year, wrote as follows: "So long as Guy's Hospital can point to this regular issue of good practical reports, amply illustrated and well printed, it may be somewhat excused for that air of self laudation which it is generally admitted is one of its characteristics." I trust that this may not apply to this address, but if by self laudation is meant pride in our history, honour to those who have made it, and love and loyalty to the hospital and school, and all its institutions, then I must indeed plead guilty.

Correspondence.

To the Editor of Guy's Hospital Gazette.

The War Memorial.

Sir,—Hundreds of Guy's men must have read the front page of their Gazette this week with feelings of mingled amazement and disapprobation at the selected inscription for the War Memorial. We are told this selection is final, but it must not be so.

The archway, whatever faults it may have, is to be our *memorial* to the Guy's men who died in the war, and the inscription starts "To the honour of those who came through," as if those who came through were actually to have prior consideration. It continues invidiously, "To the memory of those who died," as if they were to be remembered secondarily, but not necessarily honoured.

Can the committee think for a moment that any of those who came through can possibly wish that they should so much as find mention on a tablet sanctified by the names of their dead friends? The committee has weathered much criticism, it has undoubtedly had a difficult task, but it cannot presume to think that it has now earned the right to give finality to a decision which the wider representation of Guy's must surely regard as not only unhappy but quite unpermissible. The committee does not even seem to have given serious consideration to the names of the men to be inscribed on the memorial. These could have been confirmed long ago from the Hospital and School records. In five minutes I found three mistakes and two omissions, and the numbers do not appear to add up to one hundred and ten.—I am, Sir, yours faithfully,

J. A. RYLE.

Rugby.—Collection on Cup Final Day.

Dear Sir,—I enclose for publication in the Gazette, if you think fit, a copy of a letter I have to-day addressed to Mr. C. H. Edney.—Yours truly,

ERNEST R. P. HOMFRAY,
Secretary.

Dear Mr. Edney,

I beg you will accept on your own behalf, and convey to all those who so cordially co-operated with you, the very hearty thanks of my Committee for yesterday's splendid effort on behalf of our Funds.

That the collection, though organised at the last moment, should have realised the eminently satisfactory total of £157 4s. 8d., is due to the spirited support accorded by everyone concerned and a happy augury for future years.

With renewed thanks, I am, yours sincerely,

Secretary Appeal Committee.

C. H. Edney, Esq.,
Guy's College, S.E. 1.
17th March, 1921.

	£	s.	d.
Notes	4	10	0
Silver	120	13	6
Copper	32	1	2
	£157	4	8

Papers by Guy's Men.

C. Worster-Drought, M.A., M.D.: Hydrocephalus complicating cerebro-spinal fever, and its treatment.—*Journ. of Neurology and Psychopathol.*, February, 1921.

——and Another: A case of mental deficiency associated with dyspituitarism.—*Journ. of Mental Science*, 1921, Vol. lxvii., No. 276.

A Case of Actinomycosis.

C. N., 30 years, admitted under Dr. Ryle, on December 7th, 1920, for pain in left hypochondrium, loss of weight and night sweats.

F.H.—No history of tuberculosis.

P.D.I.—He was in army, 1915—1918, and never went out of England, but was on farm work for twenty-one months. He had numerous attacks of bronchitis while in the army. He has been working in stables since his discharge from the army.

H.P.D.—Admitted into Luke on March 20th, 1920, with thirty-six hours history of pain in right iliac fossa. Mr. Turner removed a gangrenous retro-cæcal appendix. There was about a pint of pus in the pelvis and peritonitis spreading upwards. A swab from peritoneum grew B. Friedländer in pure culture. On March 27th, 1920, some cellulitis around wound was present; this was incised. He was discharged to a convalescent home on May 5th, 1920; he was there three weeks and gained twelve pounds in weight, and was discharged with the drainage sinus nearly healed. About five weeks before admission he commenced to have profuse night sweats. He then noticed that he was getting thin. During the next fortnight he commenced to vomit, once in every three or four days and had a dragging pain in left hypochondrium, and was troubled by a hacking cough. No return of pain in lower abdomen. He was seen at intervals by Mr. Turner and Dr. Ryle, and some signs suggesting phthisis were found. It was decided to admit patient.

C.O.A.—Pulse 96; temperature 97·4°; respiration 28. Patient looks thin, has lost over a stone in weight. Complexion sallow, mucous membranes pale. Hands and forehead moist. Complains of slight pain in left hypochondrium.

Respiratory System.—Nothing abnormal, except a few rhonchi here and there. Sputum mostly clear mucus.

Cardio-vascular System.—No abnormalities found.

Alimentary System.—Teeth, much gingivitis.

Abdomen.—Right paramedian scar, very thin at lower end, and with small healed sinus which breaks down at intervals.

On palpation there is a tender mass, about three inches by two, under the upper fourth of the left rectus. It appears to be in the liver, which cannot be felt elsewhere. Liver dullness commences in fifth intercostal space in nipple line and extends across the axilla in a horizontal line, but seems a little higher behind than usual. Spleen not palpable. Nothing abnormal in urinary or lymphatic systems.

Blood Count.—Reds 4,960,000; hæmoglobin 70 per cent.; colour index 0·7; leucocytes 18,600 per cm.m. No abnormal cells in film.

Dr. Ryle was unable to find any signs of phthisis. The lump was thought to be either actinomycosis or a solitary pylephlebitic abscess, though the long latent period after operation made this unlikely.

X-ray showed right diaphragm higher than usual, no movement on respiration, and diaphragm somewhat obscured in vertical position.

From admission to 13th December, 1920, patient ran an irregular temperature up to 102·4°. On the 16th, in an X-ray plate, a small dense shadow was seen through shadow above the right diaphragm, suggesting a foreign body.

On the 17th Mr. Turner incised the swelling in the left lobe of the liver and about a dram of thick necrotic liver tissue was removed. This contained some suspicious granules, which on examination proved to be clumps of actinomyces.

From some yellow purulent sputum collected on the 21st, actinomyces were also recovered. Since the operation patient has continued to run a temperature up to 102·4°, and still has night sweats. On 1st January, 1921, he coughed up small lumps of reddish brown sputum, crowded with actinomycotic granules, and suggestive of liver tissue.

On 18th January, 1921 actinomyces were grown from the fæces.

On 21st February, 1921, the right base was almost completely dull with many crepitations. A large quantity of foul sputum being coughed up, and there was intermittent diarrhœa. Patient continued to run a hectic temperature until his death on 21st March, 1921. The treatment adopted was increasing doses of potassium iodide and an autogenous vaccine

Autopsy by Dr. Nicholson.—

Liver.—Under the right cupola of the diaphragm there was a small abscess cavity which had tracked through to the lung and communicated below with a liver abscess, 10 cm. broad, and containing thick pus. In the left lobe there were two similar abscesses, one of which had been opened by operation. They both showed the typical "honeycomb" appearance.

Lungs.—The right base was pneumonic and each lobe contained a small abscess. There were a few adhesions between the cæcum and the parietes, but the stump of the appendix was healthy. There was a small sub-mucous ulcer in the cæcum just below the ileo-cæcal valve.

The case is interesting from several points of view. The symptoms suggested phthisis, but the physical signs were few. Another alternative was a very small subdiaphragmatic abscess, and examination, with

this in view, revealed the lump in the liver, which had not been noticed by patient. The onset of the disease was misleading.

All the early symptoms were those of a very acute appendicitis, and after operation the course was very similar. There is no note in the surgical report as to the condition of the appendix.

This case is very similar to one described by Dr. Fawcett in a clinical lecture, published in "Guy's Hospital Gazette," of November 29th, 1919. In this Dr. Fawcett points out that by examining a film of pus, instead of a culture at the time of operation these cases might be detected early, with a marked improvement in the prognosis. The primary focus in this case was almost certainly the appendix, which is a well recognised site.

In conclusion, I wish to thank Dr. Ryle, Dr. Nicholson and Mr. Turner for permission to publish this case.

E. F. W.

Dental Society.

The last meeting of the above Society for this session was held in the College Smoking Room, on Tuesday, 15th March, Mr. E. B. Dowsett, President of the Society, being in the chair.

The minutes of the previous meeting having been read and confirmed, a casual communication was then made by Mr. M. Braun. This consisted of two cases of rather unusual interest which had come to the Dental Department for treatment. In the first a man who had an unusually large accumulation of "tartar," especially around his lower incisors, showed his left lower lateral incisor lying horizontally across the alveolar ridge, held in place by a huge mass of "tartar" and pointing directly into the mucous membrane of the lip, being buried quite a quarter of an inch, commencing ulceration being apparent. A model of this case was shown. The second case was that of a young girl of about 15—16 years of age whose dentition consisted of a number of poorly developed rudimentary temporary teeth, of a simple conical shape, two permanent canines and two permanent molars very poorly developed being the only permanent teeth present. Radiographs showed no unerupted permanent teeth of any kind to be present in the bone of the jaws. A short discussion of these cases then took place.

Mr. A. Bulleid then read a most interesting paper on "Bacteriology and its Relation to Dentistry," in which he dealt not with details of bacteriology but rather with the general aspects, and the lines upon which the work of the future in this department will probably be based. Mr. Bulleid drew attention to the value and importance of going further afield than the mouth itself in order to discover the probable causes of dental diseases, and quoted several very striking cases in which there was evident connection between development of certain organisms and certain dental affections.

The paper was exceedingly well received and the speaker was congratulated upon his effort. An interesting discussion then followed in which questions were put and many views expounded in connection with the subject. The Chairman made some very interesting remarks upon the value of research in this subject, and the lack of knowledge there is at present as regards the growth and relation of micro-organisms to dental disease.

After Mr. Bulleid had replied to questions the meeting adjourned.

The next meeting is due on 10th May, and will be the Annual Meeting for election of office bearers.

Notices.

Guy's Hospital.

A Cinderella Subscription Dance will be held in the Court Room, Guy's Hospital (by kind permission), on Thursday, 14th April, 1921, from 8 to 12 p.m.

The proceeds will be devoted to finishing the endowment of a Cot, to celebrate the completion this year of twenty-five years' work of the Guy's Hospital Ladies' Association.

Tickets, price 7/6d., may be obtained from:—

Lady Hale White, 38, Wimpole Street, W. 1.
Mrs. Rowlands, 12, Queen Anne Street, W. 1.
Mrs. Spon, 61, Harley Street, W. 1.
Mrs. Eason, Superintendent's House, Guy's Hospital, S.E. 1.

As the number of tickets is limited, it is advisable to appl early.

Guy's Hospital Medical School.

The Golding-Bird Gold Medal and Scholarship in Bacteriology have been awarded as follows:—Mr. E. H. Richards, Medal and Scholarship, £20. Mr. A. T. Rogers. Certificate.

The Junior Prizes for General Proficiency have been awarded as follows:—Mr. L. G. Housden, 1st Prize, £20. Mr. T. S. Blacklidge, Mr. G. F. Gibberd, equal £12 10s. each. Mr. E. J. Greenwood, Certificate.

The Michael Harris Prize for Anatomy has been awarded as follows:—Mr. J. J. Lewinstein, Prize, £10. Mr. J. Jemson, Certificate.

The Wooldridge Memorial Prize for Physiology has been awarded as follows:—Mr. G. F. Gibberd, Prize, £10. Mr. E. J. Greenwood, Certificate.

Reviews.

Intestinal Disinfection. By Capt. J. T. Ainslie Walker, R.A.M.C. (T.F.) (The Universal Medical Publications, Ltd.) Price 6d.

In this small brochure of 12 pages, Capt. Ainslie Walker, after having enumerated the long and terrifying list of diseases which have, at some time or another, been described as end-results of intestinal toxæmia, goes on to point out that these can all be prevented by the routine use of a new intestinal disinfectant which he has elaborated and has called Trimethol. This drug, whose full and more formidable name is trimethylomethoxyphenol, has, it is claimed, the following advantages:—it is freely soluble and mixes with the intestinal contents; it is not absorbed and is non-toxic for the intestinal mucosa; it is a strong germicide.

Apparently the author hopes, by the routine use of this drug, to rid us of most of the ills of which the flesh is heir. It seems to us that the more likely result of this wholesale and hapazard destruction of the intestinal flora (the innocent equally with the guilty) is chronic indigestion and mal-nutrition.

Clinical Bacteriology and Hæmatology for Practitioners. By W. D'Este Emery, M.D., B.Sc.Lond. (Messrs. H. K. Lewis & Co., Ltd.) Sixth edition. Price 15s. net.

The monotony of the existing literature on bacteriology is strikingly relieved by the excellence of this work. In addition to a summary of the characteristics of the important pathogenic micro-organisms, it contains also descriptions of simple methods whereby the practitioner may carry out his own bacteriological investigations. An approximate dosage of vaccine accompanies the description of each organism and should form a useful guide to this form of therapy.

The section on hæmatology is, on the whole, good though somewhat laboured in parts. It is surprising, however, that the author makes no mention of the Burker hæmacytometer which offers innumerable advantages over the Thoma Zeiss type which he describes.

The method of examination of fluid from serous cavities is adequately dealt with, but the statement that lumbar puncture is "simple, easy and devoid of danger," reveals a strain of optimism which though admirable as a quality may tend to mislead the unenlightened reader.

The book, though primarily designed for the use of practitioners, can be confidently recommended to all students as an invaluable aid to their clinical work.

Medical Science. (Oxford University Press.) Published monthly, price 3s. net. Annual subscription 30s.

The March number of *Medical Science* covers a very wide field of medical research. It deals with every branch of contemporary work on medicine and surgery and kindred sciences. The review of international work on tuberculosis is a very comprehensive epitome of the latest knowledge on the subject. Mr. W. G. Spencer, M.S., F.R.C.S., contributes an interesting paper on "Air Embolism following Thoracocentesis," which reviews much of the literature on the subject in an attempt to establish his theory that deaths or paralysis, attributed to "pleural reflex," are in reality attributable to air embolism of the cerebral vessels.

While he appears to prove, successfully, that the majority of these cases are probably cases of air embolism, this theory does not seem to fit some of the reported cases. He quotes a case of Forlaninis, in which the possibility of air embolism would seem to be precluded by the fact that the lung was so collapsed that puncture would be out of the question. In any case the susceptibility of some patients to "pleural shock" on each occasion when the pleura is punctured emphasizes the reality of this phenomenon.

This number also contains reviews of work on "Syphilis of the Nervous System," "Cancer of the Rectum," and innumerable other subjects.

Principles of General Physiology. By W. M. Bayliss, M.A., D.Sc., F.R.S. Third edition, revised. 1920. (Messrs. Longmans, Green & Co.) Price 28s.

We have all learnt to value Professor Bayliss' book for its lucid explanations of the principles on which our modern knowledge of physiology is built. We therefore welcome the appearance of a new and revised edition. At the time when the last edition was published most of the world's physiologists were busy with the problems set them by the war, and it is the results of some of these researches which have necessitated the chief of the alterations and additions to this new edition. The work begun by Dale, Laidlaw and Richards on wound-shock threw much light upon the capillary circulation. This work, together with that of Krogh on capillary circulation is admirably summarised by Professor Bayliss in his chapter upon the circulation of the blood, whilst throughout the book we find many small alterations which have been made to correllate the text with the advances made in the few years which have elapsed since the previous publication. In consequence, this book must prove invaluable to the student preparing for the higher examinations in physiology, as it offers him a concise explanation of the new researches and a thoughtful estimate of their true value.

Football.

RUGBY.

GUY'S v. BART.'S.

Final Senior Tie. United Hospitals Challenge Cup.

This match was played on the Richmond Athletic ground on Wednesday, March 16th, and one is forced to the conclusion, from the complaints that assail one, that the stand accommodation of this historic (as far as the competition is concerned) ground, is now quite inadequate to the demand for seats for this popular Final Tie.

The members of the Staff at the Hospital turned up in force, one noticed Mr. Steward, Mr. Fagge, Dr. Ryle, Mr. Bromley and Dr. Cameron quite near each other in the centre stand, and doubtless there were many others present that your reporter, whose time was fully occupied with the game, failed to see.

Guy's "Raggers" were splendidly and wonderfully arrayed and doubtless would have been much better pleased, had Bart.'s provided some opposition. It is difficult to rag by oneself, anyhow this is what happened and one must congratulate the students of Guy's who provided so much jolly good fun, all on their own.

The game commenced in a high cross wind and immediately developed into a fight for possession in the tight scrums, and these were endless. After about 5 minutes the ball came out and our three-quarters got possession but sad to relate Krige was tackled by Thomas and the hard ground sent him lame. For the rest of the game Krige only hopped around. Hard luck on him and hard luck on Guys. The line was re-arranged and F. W. Reitz came from the scrum to full back. With 7 men in the pack we held our own and at length got going, Steyn ran beautifully but he finished with a short punt, with Graham-Davies in attendance. Smuts fielded it and sent us well back. Smuts always does field the ball. He is a great full back and the short punt is folly with such a man. Next Steyn gave Davies a pass and right well the International ran. Play settled in Bart.'s "25." Marais, Van Zyl and Bekker tried to cross the line and then came good passing to the left, Albertijn making a splendid opening for Daneel, now playing on the left wing, to score our one and only try. Daneel found it impossible to convert against the wind.

After ends were changed Guy's for some time held their own the forwards being well backed up, though from many a scrum Bart.'s forwards, with

The Rugby XV.

Orchard, Shaw and Morlock always to the front, broke away very smartly. It was this quick breaking up that bottled our attack. Neser got away with a fine run but nothing came of it. Bekker made one or two dives for the line and Duncan once appeared almost over. During this period of attack none was more alert than Graham-Davies, in both attack and defence he was a great trier. Thomas, the Bart.'s International threequarter, went to right inside, but for a long time he saw little of the ball. Hard close scrum work, tremendous tackling, and the Guy's seven at length gave ground. Bart.'s got a foothold in our "25," and they gave Thomas a couple of good runs, but he was well marked. Then away went Steyn again running well, from his "25" with Graham-Davies in attendance. With only Smuts to pass he kicked. Had he given the ball to his wing man nothing could have prevented a score. All the backs played well, Reitz as a substitute full back magnificently. Bekker was well looked after by Williams. Van Schalkwijk was not in his happiest mood, he stood too close to the scrum to get his threequarters moving at top pace. Doherty, Neser and Taylor one noticed repeatedly, but one doubts if any forward worked harder than Marais, his energy was prodigious. It wasn't a big win, 1 try to nothing, but sufficient, and thus for the 18th time, we will take care of the Cup. Mr. Freethy as a referee was superfine, if such a term can be used. Fairness and firmness were never more wisely combined.

Guy's Team.—A. Daneel, H. Graham-Davies, J. A. Krige, P. K. Albertijn, C. L. Steyn, F. Bekker, J. Van Schalkwijk, W. D. Doherty, F. Reitz, C. Marais, A. H. Shelswell, R. F. H. Duncan E. E. Neser, A. H. Van Zyl and W. H. Taylor.

GUY'S v. RICHMOND.

This match was played at Richmond on March 19th, and on Monday, March 21st, a daily paper kindly headed its report of the match "Guy's Unlucky." This was very kind because it didn't seem ill luck that lost us the match but the kicking instead of running by the Hospital backs. One doesn't grudge Richmond their victory, they are a good side and since the war, have risen to their old place in London Rugby rapidly under the captaincy of H. Millett, the old Guy's and International full back.

The forwards, in the game under notice, have nothing to reproach themselves with. Doherty, Duncan, Shelswell were all splendid, and Reitz and Biddle also gave useful help. After a spell of hard footwork the Richmond men got over our line, but were brought back by the referee and then the opposing backs had a look in; luckily for us the dangerous movement broke down through an unaccepted pass. From now on until half-time our forwards gave Millett plenty to do, and he did it well. It was a treat to see the way the old Guy's man has kept his form. H. Jones and S. Cartwright helped Millett and we were kept out, so that at half-time the score sheet was a blank.

Soon after play recommenced Mackay of Richmond was awarded a penalty. Some Guy's man charged at Mackay's first attempt to goal, so he was allowed another shot. Nothing came of it. The Hospital now tired somewhat, which was not at all surprising considering the hard Cup Tie of the previous Wednesday, and Richmond assuming the aggressive, H. Jones made a strong bid for the line. Then the Richmond forwards took a hand and a little later Cartwright, who all through had been a source of anxiety to our defence, cut clean through and Millett had no difficulty in goaling. Van Schalkwijk was almost over subsequently, but failed to score and so we lost by one goal to nil.

Guy's Team.—W. Olivier, A. Daneel, C. L. Steyn, P. K. Albertijn, J. Van Niekert, F. Bekker, J. G. Van Schalkwijk, W. D. Doherty, F. W. Reitz, C. Marais, R. F. H. Duncan, A. H. Shelswell, F. J. Biddle, G. Zondagh, R. M. Macintosh.

ASSOCIATION.

GUY'S v. BART.'S.

Inter-Hospital Cup.

We met our "old enemies" again in the final of this competition on March 15th, at Chiswick. They had fought their way through much the stronger half of the draw, including as it did the London and University College Hospital, and we had our fears, none less real for being kept to ourselves, about the outlook. Nicholls, who had damaged his ankle, dropped out of the side, but luckily Van Geuns, who had missed several games for a similar reason, was fit again for his old place at outside right. Couch was moved up into the forward line to fill the vacant place at inside right and Hewetson took up the left half position.

Our old fault, delay in settling down was again evident; Bart.'s pressed at first and although play soon settled down to mid-field with occasional raids in either direction, Bart.'s were first to score. Stuart-Low, their inside right sending a swerving shot just out of Hardy's reach. Later in the first half, Van Geuns receiving the ball from the left wing, pushed it gently into the net to equalise the scores.

Half-time came with honours easy—a light ball and a gusty wind had combined to spoil the chance of good football. In the second half, one of the Bart.'s backs, who had been playing a very sound game, had to retire with a damaged knee. Evi-

dently something had "gone wrong" quite early on in the game but he had stuck to his job, kicking and tackling well until absolutely unable to continue. Even before he left we had been pressing, although unable to score; then for a spell off-side checked all our forwards' efforts. Trott burst through twice only to shoot first straight at the the goal-keeper and then outside; our other forwards finding passing impracticable, tried individualism and kept pegging away at the Bart.'s goal. First one goal fell to Williams, and during the last quarter of an hour, apparently Bart.'s were "done" and we put on three more goals. Result:—Guy's 5, Bart.'s 1.

Guy's Team.—E. Hardy, C. A. Wakeford, A. W. Riddolls, O. T. Painter, D. J. P. O'Meara, J. C. Hewetson, R. Van Geuns, D. H. Couch, L. S. Williams, L. A. S. Trott, V. R. Morgan.

Perhaps the final score rather over-estimates our superiority; still, for once, we seemed fitter than our opponents, and for the last half-hour or so the play was entirely in our hands. Among the forwards Trott showed some extraordinarily good football, and then some shooting best described as the reverse. Williams played with dash, shot well, and generally kept the line together; Morgan and Van Geuns did their share, although the latter was noticeably timid at first; Couch was only rarely in the picture but then, even the best of half backs cannot become a forward in a day. The defence all did well; Painter early had the measure of his wing and put in some valuable attacking work, Hewetson undertook the thankless job of filling Couch's place, and did it well. O'Meara tired rather early, but till then his head was everywhere—even in the way of one or two of his own kicks.

The Association XI.

GUY'S v. KING'S COLLEGE.

University of London Cup.

After relatively easy games in the preliminary rounds, Guy's remained to contest the final round with King's College. The match was played on Monday, March 21st, at Highbury; this, the Woolwich Arsenal ground was a desolate sight. Our own supporters were disappointingly few, and even the crowds of King's students, garbed for the occasion, and armed with the noise-producing instruments a final seems to demand, were too few to fill even the stand. Nicholls was still unable to play, and we were also without O'Meara; Duncan appeared as outside-right, temporarily forsaking Rugger, and various re-arrangements were made.

The game opened with a display of miskicking by both sides—the ground was very greasy, and the ball light and difficult to control in the wind which prevailed. King's apparently adapted themselves more readily to the conditions: their centre forward was always dangerous, and their wing men put in some fast runs. After about twenty minutes we were one goal down, the ball going through off one of the posts after a melée; shortly afterwards Hardy threw himself at a fast shot and brought off a good save. During the rest of this half our forwards never showed cohesion sufficient to worry the opposing defence, and King's were able to attack again and again—ultimately scoring another point.

During the second half, we had matters much more our own way, except for the first few minutes when Hardy, who had run out to clear, saw a long shot hit the cross-bar of an undefended goal, and luckily rebound into play. Our opponents seemed inclined to be satisfied with their lead; their backs gave a vigorous exhibition of touch-finding, but now, in turn, their forward line appeared impotent. Our half back line assumed more of a control over the game, and the backs, none too certain in the first half, dashed in again and again to intercept a pass and send the ball back to our forwards. The latter, too, had apparently recovered confidence, and our hopes ran high when Van Geuns scored. As time drew nigh frantic endeavours were made to get on terms, but without avail. The end came with the score 2—1 against us, and so another cup is lost to us for the present.

Guy's Team.—E. Hardy, C. A. Wakeford, A. W. Riddolls, O. T. Painter, D. H. Couch, J. C. Hewetson, R. F. H. Duncan, R. Van Geuns, L. S. Williams, L. S. Trott, V. R. Morgan.

The game was fought at a good pace, and in a good spirit, and King's deservedly won, making better use of their opportunities. It was unfortunate that O'Meara was obliged to drop out of the side at the last moment, as one cannot help thinking that the first goal at least came before the team had settled down to their new positions. Probably our half back line was the strongest part of the team; Couch was ubiquitous, though erratic at times, while the wing halves got in some solid work. Among the forwards, Van Geuns and Williams were the most prominent; the left wing were not as good as we know they can be—Duncan, too, was disappointing when one remembers how well he played in the corresponding match last year; still to turn to Soccer almost before the newly-won Rugger Cup is dry is in itself an achievement limited to few.

GUY'S v. BART.'S.

Junior Inter-Hospital Cup.

The Junior Inter-Hospital Cup Final was played at Honor Oak Park on Saturday, March 19th. As usual, Bart.'s provided the opposition, but on this occasion they did not go empty away. Our forwards, with the exception of Weyman and Gonsalves on the left wing, were grievously disappointing. Bart.'s led 2—1 until an individual effort on the part of the last named put us on even terms. During extra time, which was played to settle the destination of the cup, Bart.'s scored once without response, and thus retired winners by 3—2. It was unfortunate that we were deprived of the services of three of our regular players; Hewetson, the 2nd XI captain was unavailable as he had played in the senior competition as a substitute for one of their "crocks." Our defence was scarcely as sound as usual, Mackeith's judgment being at fault with at least one of the goals.

Guy's Team.—Mackeith, Sennitt, Fripp, Palfrey, Danino, Robertson, Kendrick, Graham, Rowbotham, Gonsalves and Weyman.

Hockey.

Guy's lost to St. Thomas's in the Final of the Hockey Cup, on Friday, March 18th, by 5 goals to 0. An account will be published in the next issue of the Gazette.

Swimming Club.

At a General Meeting of the above Club, held on Tuesday, March 8th, 1921, Sir Alfred Fripp in the chair, the following officers were elected for the ensuing season:—

President.—Sir Alfred Fripp, K.C.V.O, C.B., M.S., F.R.C.S.

Vice-Presidents.—All re-elected.

Water Polo Captain.—C. A. Wakeford.

Swimming Captain.—R. Jarman.

Hon. Secretary and Treasurer.—F. S. Hutchinson.

Committee.—G. Cohen, O. F. Painter, R. Schofield, W. Kempster, J. Silver.

Delegate to S.C.A.S.A. and R.L.S.A.—F. S. Hutchinson.

During the meeting it was suggested that a Committee Meeting should be held as early as possible to discuss various matters of importance, *e.g.*, Headquarters of the Club, Gala Night, and to create enthusiasm amongst the students to swim.

A vote of thanks was passed to Sir Alfred Fripp for taking the chair.

F. S. HUTCHINSON.,
Secretary.

Fixtures.

April 28	Grafton S.C. (Forest Hill)	...	Away
May 10	St. John's College, Cambridge	...	Away
„ 11	Marcians S.C. (Walham Green)	...	Away
„ 13	"X" Division Met. Police ...	...	Home
„ 14	St. Paul's School (Baron's Court)		Away
„ 27	St. John's College, Cambridge	...	Home

June	8	Middlesex Hospital	Away
„	10	University College	Away
„	17	Old Citizens	Home
„	24	Marcians S.C.	Home
July	8	Middlesex Hospital	Home
„	15	Grafton S.C.	Home
Sept.	9	Richmond S.C.	Away

To the above fixtures there are several more to be added, including Cup Tie Draws for Inter-Hospital and University Cups, and a number of fixtures for the second team. Complete list of fixtures can be obtained by buying a fixture card at the commencement of the Summer Term.

It is noticeable throughout the life of Sport in the Hospital, that Rugby and Association are followed keenly during the winter—Tennis and Cricket take their places in the summer. This leaves the minor sports, such as Swimming, the subject of this article, with few or no supporters.

For the past two years the keen supporters of the Swimming Committee have had no help whatsoever from the average student. This year it is desired that everybody who knows how to swim, slowly or quickly, should double, nay, treble his zeal and become efficient.

The Hospital have won the Cup for the past two years, and as the other hospitals are making serious efforts to take it away from us, keen and arduous support will help "to bring it back to dear old Guy's again." There are two Swimming and two Water Polo teams being formed this year. Members of the Committee are more than willing to help and teach beginners, and at the same time coach the more advanced artists. Think! why shouldn't everybody be able to float, to do the breast stroke, yea, more, the awe inspiring "crawl."

At present it is undecided whether Lavington Street Baths or Shoreditch Baths are to be our headquarters. As the former are nearer the Hospital it is hoped that these will be available. Whether this is the case or not, all swimmers are asked to practice there at lunch time or after their work is finished at the Hospital. There will be a Water Polo ball available for practice. It is hoped that everybody will start practicing at the earliest opportunity as trials for the four teams will be held in the first fortnight of May. Students who find that they do not come up to the required standard, do not want to give up without a fight, like the majority did last year, but turn up to the Baths and practice, thereby improving themselves and their chances for a place in one of the teams.

As an Inter-Hospital Gala will be held in June, all supporters should make this a Guy's night and in doing so, establish their supremacy by running away with all the events.

Full particulars of the Cup Ties, Gala Night, Fixtures and so on will be posted up in the Colonnade and confirmed in the Gazette.

Guy's swimming shorts and badges for costumes can be obtained from S. Probert's in the Boro'.

Fixture cards may be obtained from the Secretary and the Committee.

Inter-Firm Tug-of-War.

On Friday, March 18th, in the Park, before Mr. Bellingham Smith, Sister Alice, and a large and fashionable gathering of sisters, nurses and ward-maids, one of the forgotten pre-war Hospital traditions was revived. This was a contest for the Inter-Firm Tug-of-War Cup. This cup, which was won long ago by an earlier generation of gynæcologists, had remained uncontested for some years as a ward ornament in Queen. At last, however, a challenge was issued to the Gynæcological Unit by Mr. Rowlands' Firm. It was accepted and a day fixed for the encounter. Excitement ran high on this fatal morning, and points of vantage in the Nurses Home and at the windows of the Medical wards overlooking the Park were occupied at an early hour.

By the time the rope had been manned the unruly crowd of spectators had surged right on to the field of the contest and bade fair to impede the contestants. However, under the strict and strenuous care of Doc. Hancock, who was judging the event, we at last got started.

The first pull was a long one, and as it progressed more and more of the men that were within shouting distance of the rope constituted themselves amateur coaches, till at last the Borough rang with confused shouts—"Heave, Queen, heave," rising well above the unwieldy cry of "Pull up the Rolanders." After a few strenuous minutes the Rowlands' Firm were dragged beyond the line and ends were changed for the second tug. This was an easy win of the Rowlands' Firm; they seemed hardly to have touched the rope ere they had their opponents sliding over in a bunch. The final tug was again a well contested one and resulted in a win for Queen who thus retained possession of the Cup by 2 pulls to 1.

The Cup was presented to the captain of the winning team by Sister Alice, who made a speech expressing her delight at having been privileged to watch the splendid way in which the rival firms had united to tear up the Park's sacred turf. A tiny tot from Dorcas then presented Sister Alice with a box of chocolates and the proceedings ended with vociferous cheering.

The Rowlands' Firm have done good service by so reviving such a happy tradition and one hopes that frequent contests will prevent this tradition from lapsing again into obscurity.

Births.

COCKS.—On March 22nd, 1921, at Knapdale, Brown Town, P.O. Jamaica, the wife of Gilbert Anderson Cocks (née Shaw-Allen)—a daughter.

DEBENHAM.—On 6th March, 1921, to Anna (née Archer-Shee), wife of L. S. Debenham—a son.

KILLPACK.—On March 17th, at Tanbridge, Haywards Heath, the wife (née Gimson) of C. D. Killpack, M.B., B.S.—a son.

TODD.—To Mr. and Mrs. Alan H. Todd, F.R.C.S.—a son.

Ed.—M. E. S.

GUY'S HOSPITAL GAZETTE.

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Passim.

DURING the past week we have received several letters offering both favourable and adverse criticism of our attitude towards the proposed inscriptions for the War Memorial, but we regret that we have not received many alternative suggestions to the inscription which the Committee had adopted, and which almost everyone else has condemned. Dr. Astley Clarke insists, in a letter which we publish on another page, that our contention that our memorial should be primarily a memorial to our dead friends, is wrong. He fears that it will become a dead and meaningless symbol if we seek only to commemorate the fallen, and he suggests that by commemorating those who endured hardships we shall inspire future generations of Guy's men to similar great efforts. He therefore suggests this as an inscription:

"To the Glory of those of Guy's who did their part, and to the Honoured Memory of those who fell in doing it."

This is, of course, the old condemned inscription glossed over. It is open to nearly all the objections levelled at its predecessor. It gives glory first to those who survive and memory secondarily to those who have lost all save memory. This cannot be. We would say in answer to Dr. Clarke, that Guy's men can find no greater and no more lasting inspiration to great deeds than the memory of those who have gone before. We would commend to him another quotation which has been suggested as a suitable one for the Memorial:

"Once for all they gave their all
How can we once forget."

Another proposed inscription runs:—

"Brothers sleep well; we who remain
salute you."

To this we would object that it is not only, we that remain, that will offer salutation to those that are gone, but generations still to come, that will be taught to honour and to thank the men that laid down their lives in the war.. The memorial stands already uniting almost symbolically the medical side of the hospital with the surgical. It is already almost an integral part of the hospital, and soon we will have forgotten what the Maze Pond entrance was without it. On such a permanent arch we must put no transient and no ugly inscription. The correspondence which has come to us during the last fortnight has not convinced us that there is any quotation more suitable than the reverent and simple phrase we advocated in the last GAZETTE

"Their name liveth for evermore."

The election of the Council of the Royal College of Surgeons is now approaching. Guy's has at present only two representatives upon this important council, and only one of these (Mr. Steward) is on our active staff. The other representative is Sir Charters Symonds, who is now upon the consulting staff. Under these circumstances we would appeal to all Guy's men who are Fellows of the Royal College of Surgeons, to vote themselves for Mr. Fagge, who is our candidate this year, and to persuade all their friends who have votes to give them to him. Mr. Fagge has held several important administrative appointments with the Royal Society of Medicine, the Association of Surgeons, and the Surgical Club. In this way he has not only become experienced in such administrative work as is demanded by the Council of the Royal College of Surgeons but has also come into contact with a great number of the surgeons of this country. Thus he would be an ideal Councillor, and will be, if only Guy's men will answer this appeal and will both vote and canvass for him.

We are very pleased to announce the appointment of Dr. E. C. Gray to be Professor of Chemistry in the University of Cairo. Dr. Gray was a student here only a few years ago. He qualified in 1918, and was during 1917 Demonstrator of Physiology. He served as Surgeon Sub-Lieutenant in the Navy in 1918, and after his demobilization he went to the Lister Institute, where he conducted research upon the enzyme content of certain bacteria. For this work he was awarded the D.Sc. Dr. Gray is perhaps best known to readers of the Gazette as "Ho-Ho," the witty writer of a series of letters which have appeared from time to time in these columns satirising the varied phases of hospital life. We trust that Dr. Gray, in the dignity of his professorial chair, will not put by his pen, but will send us from time to time letters about his new university either as he sees it himself or as it is seen by his Celestial alter ego.

For the last two weeks tree felling in the Park has again been occupying the attention of the Works Department. We have lost nearly all the smaller trees which formed a second file in the shadow of the big trees bordering the drive in front of Hunt's house. Their loss is hardly to be regretted, for they have always been diminutive in size and of very little beauty. This was unfortunately not the end of the tale, for having uprooted these Lilliputians, the Works Department turned its attention to their taller brethren. Two of the big trees were selected and immediately decapitated, we presume—pour encourager les autres. Later, after much labour, they were drawn—from the ground—and quartered. This was in theory quite all right, for the trees had long become one long tangled mass from the south end of the colonnade to the door of Hunt's house. Each tree encroached upon its neighbours and interfered with their proper growth. A judicious thinning might then have resulted in a few years time in the increased glory of the survivors. What has been done though is hardly judicious. Two adjacent trees have been felled. So the majority of the trees still remain cramped and unhealthy whilst there remains in the centre an irregular and unsightly gap. Had alternate trees been chosen (there was very little difference in vigour between the trees that were sacrificed and those that remain), they might still have remained symmetrical. The Park has ever been a welcome oasis whither we might escape on sunny days from the depressingly squalid architecture of the Borough. It cannot stand any further destruction; there remain now only sufficient trees and hardly sufficient grass to justify our calling it the Park.

If the Hospital forestry corps were to devote less time to tree felling and more to grass planting we should be better served.

On April 7th, for the first time since pre-war days, a Prize Essay was read before the Physical Society. We were glad to welcome Dr. Lauriston Shaw as president for the evening, and we join with him in the congratulations which he extended to Mr. McKeith on the excellence of his essay on so difficult a subject. The Physical Society has thus brought to a close a successful session, and although on occasions the attendances have been few in number, yet all those that came appreciated, we are sure, the value of the spirited discussions which took place, especially at clinical meetings, on the differential diagnosis of cases.

We publish on this page particulars of a Dental Research Fund which has just been instituted at the Hospital. Although, as Mr. Bocquet Bull informs us, some work has already been done in the Chemical Department under the auspices of the Dental Department, upon the composition of dental amalgams, yet this is the first money definitely set aside by the Hospital for the encouragement of Dental Research. We hope that this Research Fellowship will stimulate the newly qualified and qualifying dental students in widespread original investigations, so that the Guy's Dental School may soon come to be known, not only by the merit of the practitioners which it has trained, but also by the progress which will have been made in all the many branches of dentistry by the Research Fellows working here at Guy's

There are two lectures shortly to be delivered at the Hospital which all lovers of Guy's and its traditions should make a point of attending. The first is to be given by Sir William Hale-White on "What Medicine owes to Bright," the second by Mr. Williamson on "Guy's and its History." Sir William Hale-White's lecture will be given on Friday, 22nd April, in the Anatomical Theatre at 12.0 noon; Mr. Williamson's in the Pathological Theatre at a date which will be announced later.

We have received from the National Hospital for the Paralysed and Epileptic, Queen Square, a syllabus of the lectures and demonstrations which are to be given in their postgraduate course in May and June. Particulars of these lectures, which are to be given by some of the leading neurologists of the day, and which cover most of the clinical conditions yet recognised in neurology, may be obtained from the Dean of the National Hospital, Queen Square.

May we point out to our anonymous correspondent who signs himself "Student," that we at all times object to receiving such scurrilous letters as his, and especially do we so object when such letters arrive insufficiently stamped.

Dental Research Fellowship Fund.

This Fund has been instituted for the purpose of Dental Research, and consists of a sum of money not exceeding £300 per annum, awarded wholly or in part.

Applicants, whether Graduates or Undergraduates, must have studied in the Medical School or Dental School of Guy's Hospital, unless the Advisory Body decides that the circumstances are exceptional.

Holders of Grants from the Fund may, at the discretion of the Advisory Body, be part time Research Workers.

All Research Work undertaken with the aid of the Fund must be entirely carried out in Guy's Hospital or the Schools attached thereto, unless the Advisory Body agrees that, from the nature of the work, some portion of the study might, with advantage, be pursued elsewhere.

Applications for Grants from the above Fund should be made to the Clinical Research Committee of Guy's Hospital, London Bridge, S.E. 1.

The Indications for, and the Results of, Splenectomy, excluding Splenectomy for Injury or Misplacement of the Spleen.

Being the Treasurer's Prize Essay read before the Physical Society by Mr. M. H. MacKeith on April 7th, 1921.

At first sight, it would seem reasonable, in considering the removal of such an organ as the spleen, to appeal to the physiologist for a detailed account of the functions of the organ in health. While such an account, however, forms a useful preliminary to further discussion of the subject, we must recognise that conclusions drawn in the laboratory from the microscopical examination of the tissues and cells constituting the organ, or from the effects of extracts of the viscus on digestive and other metabolic activities in vitro, or in the experimental animal, are of relatively slight importance.

A resumé of present day views on splenic function will be given, and then the results of splenectomy in the experimental animal will be discussed more fully, since on these we must place most reliance both in estimating splenic function and in predicting the effects of operative removal of the spleen in man.

The physiologist divides splenic activities into four groups:—(a) hæmopoietic, (b) reticulo-endothelial, (c) digestive, and (d) endocrinous.

During fœtal life the spleen plays a prominent part in the formation of red blood corpuscles and of neutrophil leucocytes. In adult life, however, although the production of white cells occurs under the influence of various infections—red blood cell formation is re-established but rarely. In the leukæmias the spleen-pulp cells, morphologically and developmentally the equivalent of the endothelial cells of the bone marrow, take on the leucocyte forming powers restricted in the healthy adult to the latter group. That these spleen-pulp cells are important mechanisms for the destruction of effete red blood corpuscles is almost evident on microscopical examination of spleen preparations. The venous outflow from the spleen passes directly into the great chemical laboratory of the body—the liver—and it is but reasonable to suppose that this anatomical arrangement is admirably adapted to bring the iron-containing products resulting from hæmoglobin breakdown to the organ best fitted to build them up again into the more complex bodies needed in the synthesis of new hæmoglobin.

In splenectomised animals, the task of red cells destruction falls entirely to the bone marrow and lymph glands—here the actual breakdown is carried out as efficiently, but the synthetic procedure is interrupted—the excretion of iron is increased and the process of recovery from a loss of blood is prolonged. Splenectomy, too, is found to result in a decreased production of bile pigments, *i.e.*, a decrease of hæmoglobin breakdown in the liver.

Yet another function appears to be dependent on the endothelial cells of the spleen pulp; their phagocytic activity readily accounts for the large number of micro-organisms which they take up, although their destructive powers do not appear to be as well developed as their ingestive ones. In the light of the cellular theory of immunity, the protective mechanisms of the body against infection would seem to lie in the endothelial cells of the widespread lymphoid tissue. Such a view is warmly advocated by Sajous in his book on the relation of the Internal Secretions to Medicine, and its application to a limited area of the reticulo-endothelial system, as it may conveniently be called, is traceable in Kenelm Digby's book (Immunity in Health). The earlier experiments in the resistance of splenectomised animals to infection were vitiated by several factors one of the most important of which was that the operation itself—a severe one— was an influence absent in the controls. Morris and Bullock (Annals of Surgery, 1919) compared the resistance of splenectomised rats with that of similar animals in whom one testicle had been removed intra-peritoneally—an operative procedure of approximately equal severity. Their results, based on work carried out with every care, seem to establish incontrovertibly that removal of the spleen diminishes to a marked degree the resistance of the individual (rat) to chance or intentional infection.

Though arguments based on phylogenetic evidence are notoriously dangerous, the fact that the spleen draws its blood supply from the cœliac axis, in common with the stomach, liver and pancreas, would encourage the belief that this organ is concerned with digestion. The rhythmic variations in size of the spleen, showing as they do a periodicity corresponding to the ingestion of food, and to the leucocytosis associated with digestion, have been explained as part of a mechanism for the detoxication of proteins absorbed. Richet found in splenectomised dogs an increased deposit of fat, which he explained as due to an alteration in metabolic activity; his experimental results have lacked later confirmation, and, in any case, present physiological fashion would tend to attribute such a variation in the "habit" of the individual to alteration of endocrine balance. Moynihan in an early case, stated that digestion leucocytosis did not occur after splenectomy; this result has not been supported by

more recent observation. Splenic extracts show a high purin content, and also the presence of enzymes calculated to deal with the products of nucleo-protein breakdown—the splenic blood passing to the liver may aid the latter organ in dealing with the results of protein digestion.

With regard to the spleen as a ductless gland, its position is difficult to define. Formerly occupying a prominent place as the largest member of this group, its relation to the blood system has of late been emphasised almost to its exclusion from the endocrine glands. Early splenectomy workers described a general increase in the fatness of the animals and a decreased fertility; these results, strongly suggestive of interaction with the thyroid-pituitary group and with the gonads, have not been confirmed by later workers, but the established fact, that removal of the thyroid in a previously splenectomised animal does *not* cause its death, seems definite evidence demanding the re-instatement of the spleen in the complex of endocrine glands.

The effects of splenic extracts on gastro-intestinal movements, now commercially exploited, are not evidence of the same degree of importance.

To return to our subject, in the case of the spleen we lack the results of Nature's experiments in the laboratory of life; congenital absence of the spleen is a rarity, and none of the few described cases have fallen, during life, into the hands of those qualified to observe their variation from normal metabolic standards.

Experimental removal of the spleen in the "laboratory animal" must be first considered because the greater extent of the material investigated has permitted a much higher degree of certainty in the results—the individual variation of the subject of observation is diminished in importance by the use of a large number of subjects, and the omnipresent possibility of personal error on the observer's side is adequately dealt with by comparison of the results of different observers.

Malpighi, in 1669, performed the first excision of the spleen—a functional "excision"—in a dog by ligating the vessels in the pedicle. Subsequent investigation showed atrophy of the spleen and an enlargement of the liver—the first recorded result of spleen excision. By the first half of the nineteenth century operative removal of this organ in dogs had been carried out by several; an increase in size and activity of the lymph glands and bone marrow after splenectomy were later described, and also a temporary rise in red and fall in white blood corpuscles —*associated with a diminution in the capacity to* compensate for later loss of blood by hæmorrhage.

Several of the earlier observers had remarked what would at the present day be called an increased exercise tolerance in their splenectomised dogs. In the light of more recent work it would appear likely that here we have an interesting example of suggestion; traditional almost from the earliest times was the connection of the spleen with the "wind" of athletes. Osler dismisses as, at least, doubtful the reference to splenectomy in Pliny—described there as a measure calculated to improve an athlete's running. Other passages based on the same belief are widespread in the literature of the Middle Ages.

When, in the closing stages of the last century, Pappenheim and others provided the clinical pathologist with the necessary methods for investigation of the blood and blood forming organs, the place of the spleen in "blood metabolism" became much more clear. Once its importance was realised, the investigation of the blood changes resulting from splenectomy became a necessity. Many have worked in this field, but the most exhaustive work has been that of Pearce and his collaborators (of Philadelphia) whose extensive experiments on dogs are the basis, and indeed, almost the sum, of our knowledge of to-day. In common with many other observers, he reports an initial leucocytosis of 26,000—38,000 on the day after the operation, with a rapid fall to 20,000 and then a gradual fall to normal at about the fourth month. The increase in white cells is mainly polymorphonuclear in character, but a transient eosinophilia also occurs, there being a *relative* diminution of the lymphocytes.

After removal of the spleen, to quote Pearce again, there is a gradual progressive anæmia which comes on promptly after the removal of the spleen and reaches a maximum four to six weeks after the operation; the return of the red cell count to normal takes place in three or four months, but the hæmoglobin percentage is not restored to its full *value until some months later.*

Such are the results as far as the blood picture is concerned—when, however, we subject them to a critical analysis, we find that there are two factors to be considered (a) the absence of the spleen, and (b) the actual operation, certainly a severe one, involving as it does extensive intra-abdominal manipulation, even although blood loss may be reduced to a minimum in the hands of skilled workers.

Meleney (Annals of Surgery, 1918) has shown that in non-infected surgical cases subjected to operation there is an immediate leucocytosis by which the number of white cells is raised to, at least, double the pre-operative figure—the leucocytosis is mainly polymorphonuclear in character, and passes off in four days or so. With regard to the red cells, there is a trivial immediate rise, probably an expression of the blood concentration of shock, and a subsequent progressive anæmia amounting at the end of about 10 days to a diminution in the red cell count of about half-a-million.

Pearce himself, in the light of the last-mentioned results is inclined to attribute the main changes in the blood picture after splenectomy to the actual operation, but in this he is not followed by Banti and the Italian school; probably the immediate results are due to the operative interference, but the prolonged anæmia and leucocytosis are associated with the absence of the spleen.

The phenomena associated with other parts of the hæmopoietic system, *viz.*, the swelling of the peripheral lymph glands and the hyperplasia of the bone marrow are still sub judice; supported by Moynihan in a recent Bradshaw lecture they are contradicted again in Medical Science Abstracts (January, 1921).

Pearce has established yet another effect of splenectomy—one whose great practical importance will become manifest later. The red cells of the splenectomised animal are found to become more resistant to hæmolysis—tested in vitro by the lowering of the concentration and osmotic pressure of salt solutions in which hæmolysis occurs, *i.e.*, by the increased *change* in osmotic pressure required to cause hæmolysis. Similar results are also obtained in vivo on injection of hæmolytic drugs; in the intact animal jaundice is more easily produced and other phenomena—hæmaturia, for example, also occur proportionately more readily.

That such an increased "fragility" to whatever it may be due, is not always cured by splenectomy, is shown very strikingly by Lord Dawson's investigations on the red cells of a case of Sir Spencer Wells', in which twenty-seven years after the splenectomy "increased fragility" was still present. Such an experience is, however, extremely rare, if not unique.

Having thus summarised the present state of our knowledge of splenic function in health and of splenectomy in the normal individual, we pass on to consider the effects of removal of the organ in disease.

The earliest splenectomy which is extensively recorded is that performed by an Italian surgeon, Zaccarello, in 1549, for what was apparently a malarial splenomegaly, if, indeed, we may trust the evidence that the organ removed was the spleen. Here the indication for operative iterference was the size of the organ and the resulting embarrassment of respiration.

From this time until after the middle of the last century the operation was reserved for hernia of the spleen through wounds of the abdominal parietes. During the ensuing 30 or 40 years it gradually became more and more the current practice to extirpate the spleen in "strictly surgical" conditions, such as neoplasiæ and animal parasitic accumulations.

It was not until more recently, when pathological research and animal experiment upon the blood system and upon the glands of internal and external secretion, had accentuated the value of the splenic factor in a number of abnormal conditions of the blood and glandular system, that numerous lesions of the spleen previously considered dominantly medical considerations came to lie in the sphere of surgery.

Now splenectomy is performed (a) for trauma and hæmorrhage, (b) for parasitic collections and displacements—lesions limited to the spleen, and (c) for a growing group of cases in which splenic enlargement has emphasised the part played by that organ in general diseases, associated with yet other conditions, in which pathological research has shown a heavy incidence of the disease process on the spleen and in which splenectomy, undertaken almost as a counsel of despair, has effected improvement, and has, in consequence, become an accredited mode of treatment, to some extent on empirical grounds.

Splenectomy for trauma, whether for hernia and infection of the organ or for rupture and consequent hæmorrhage, is excluded from the field of this paper. It is, however, permissible to mention that in such cases the results of splenectomy seem comparable with those observed in work on animals. Thus, Schultz found the red cells (in a case of splenectomy for rupture of the viscus) remained below 4,000,000 for one and a half months, and that, whereas at the end of four months the red blood cell count was normal, there was still a deficiency in hæmoglobin content. In his case, too, there was a hyperleucocytosis lasting for a considerable time, and a transient eosinophilia.

These results were confirmed by several cases studied by Hitzrot (Annals of Surgery, 1918)—the hæmoglobin fell steadily for one month and rose to normal about the end of one year; the red blood cell decrease lasted about four months. The leucocytosis and eosinophilia were also confirmed. Hitzrot, too, was able to demonstrate an increased resistance of the red cells to hæmolysis—a similar result to that found by Pearce in dogs, and one which was still present after the lapse of several months. The increase in iron excretion is confirmed for man by Bayer. An increase in the number of "vital staining" red cells had been described, but this is probably a sign of recuperation after the hæmorrhage associated with the operation.

The picture resulting from splenectomy in the normal individual is seen in its clearest form in operations performed for cysts of the spleen, or for displaced spleens, *i.e.*, in cases in which we may assume that the patient had a normally functioning spleen before the operation. It suffices to say that such cases bear out the previously described phenomena with the exception that—as there had been no preliminary loss of blood—the post-operative anæmia and leucocytosis are less marked in extent; the time relations of the rehabilitatory process remain the same. The character of the leu-

cocytosis is naturally obscured when, as in one of Hitzrot's cases, the operation is performed for a large single echinococcus cyst of the spleen.

To sum up the knowledge derived from the above cases—those in which there appears to be no general abnormality, but a condition involving the spleen alone—we may conclude that the results differ in no respect from those expected on the basis of animal experiments. In such cases surgical interference is indicated when the enlargement or misplacement of the organ gives rise to severe pain or disability, or when, as in the case of an echinococcus cyst, delay might lead to dissemination of the morbid process. Even in the hand of the skilled surgeon, splenectomy is not an operation lightly to be undertaken; extensive in character, it lays the patient open to the possibility of any one of the disasters which even the niceties of modern surgical technique have not been able completely to abolish.

On the other hand, it must be realised that delay may result in the formation of adhesions or in increase of the size and blood-supply of the organ, either of which adds in no small measure to the difficulties which the operator has to face when ultimately he deals with the case.

Between rushing to the surgeon in any splenic displacement with slight resulting pain, and postponing recourse to the operator until "deadly and scientific delay" has complicated his problem—between these two lies the golden mean.

The dominant clinical phenomenon on account of which we accuse the spleen is splenomegaly, *i.e.*, an enlargement of the spleen appreciable by ordinary methods of physical examination, signifying probably an increase in bulk of the organ to twice its natural size. Such an idea must be qualified by an appreciation of the facts that splenic disease may well exist before an enlargement of such degree has taken place, and also that in some conditions post-mortem investigation may show definite disease of a spleen not enlarged during life.

One class of splenic enlargement includes the following examples:—

1. Splenomegaly in infectious diseases (typhoid, malaria, malignant endocarditis, tuberculosis, etc.).
2. Splenomegaly of chronic venous congestion due to cardiac or pulmonary disease.
3. Splenomegaly of amyloid disease.
4. Splenomegaly of syphilis.

In the above cases it will readily be seen that, in the majority at least, the disease is so wide spread that the removal of an organ secondarily affected (*e.g.*, in malignant endocarditis or amyloid disease) has no practical recommendation. In typhoid, "spontaneous" rupture of the organ (*i.e.*, consequent on very slight trauma) occurs; splenectomy here is required to control hæmorrhage and the effects of the removal are parallel to those in the normal individual. In Conner and Downes' case (Annals of Surgery, 1918) recovery of the lost hæmoglobin may have been more rapid than usual.

In malaria, the historic precedent mentioned above (Zaccarello) has remained. In this disease, in the spleen in preference to any other organ the red blood corpscles harbouring the plasmodium are destroyed, and the parasites liberated. These accumulate in the splenic lacunæ, and give out their metabolic products. Even if the general infection of the body by the parasite is controlled by suitable treatment, there is a great tendency for the spleen to resist therapeutic measures, to remain a source from which systemic re-infection takes place, and also to constitute a menace to the activity of the liver, since the latter is subjected to the action not only of parasites escaping from the spleen, but also of the metabolites arising from the parasites and from broken down red corpuscles. The pathological basis of splenectomy in malarial splenomegaly is obvious, but results in some cases are disappointing. In a 1917 collection of 66 cases the immediate mortality was low, but freedom from re-infection or rather recrudescence was not always secured.

Splenic enlargement in tubercle is usually part of a diffuse spread of the infection; in a few cases, however, a tuberculosis apparently primary in the spleen has been recorded, there the reasons for removal are precisely the same as in malaria; here the percentage of complete recoveries is high.

In the Mayo clinic, splenectomy has been undertaken on 10 occasions for the splenomegaly of septic infection in cases in which the splenic affection resisted other treatment and the general condition was good. The "Hospital recovery" percentage is 80 so the method, in the hands of the experienced, is of value.

As in malaria, so in some cases of syphilis, W. J. Mayo records five cases in which he removed enlarged spleens in conditions of chronic intractable syphilis with severe anæmia, when the patient had been resistant to careful anti-luetic treatment carried out for a considerable period. After removal of the spleen, the anæmia quickly disappeared, and the syphilis was cured with comparatively mild anti-luetic treatment such as had previously failed to affect either the syphilitic condition or the spleen.

Here, too, the splenomegaly of Kala-Azar is to be considered; so far operation in such cases has not met with much success, but none of the cases have been sufficiently extensively reported to enable one to realise whether other than splenic involvement was present. In this disease the modern methods of medication seem sufficiently promising to be persevered with.

The second great class of splenomegalies consists of those associated with cirrhosis of any of the four types classified below:—

1. Syphilitic cirrhosis.

2. The cirrhosis associated with congenital obliteration of the bile ducts and splenomegaly.

3. Portal cirrhosis—alcoholic and otherwise.

4. The Hanot type—biliary cirrhosis—including here the form described by French writers in which the splenic enlargement precedes that of the liver and is, proportionately, greater in extent.

In all the above the antecedent or coincident hepatic disease renders it unlikely that any operation directed toward the spleen would offer any benefit. Mayo, however, in a paper before the New York Academy of Medicine stated that the spleen had been removed with benefit four times for biliary cirrhosis, and also considered splenectomy of value in portal cirrhosis in young individuals without an alcoholic history.

The observation of enlargement of the spleen in what we now know as leukæmia pre-dated Hughes Bennett's observation of the "suppuration of the blood" which occurred in this condition. So prominent was the splenic factor that as early as 1866 and 1867 Bryant of Guy's performed splenectomy; both patients, however, died rapidly of hæmorrhage; Bryant's comments on his cases are excellent examples of true insight. "We have learnt," he writes, "two things from the cases related. Firstly, that enlargement of the spleen in leucocythæmia appears to be only a part of a general disease affecting the glandular system, as a whole; and, secondly, that in splenectomy for such a disease there is a predisposition to hæmorrhage with which surgery is not competent to deal. It can neither be foreseen by any amount of care, or coped with by any amount of skill. Under these circumstances there is no shirking the conclusion that the operation is physiologically unsound and surgically unsafe, and, for leucocythæmia, should not be performed."

Here for long the position remained; the records of splenectomy in leukæmia, acute or chronic, were a long series of deaths either immediately or soon after the operation. Modern medicine, by the aid of X-rays, radium applications, and careful graduated benzol "poisoning," is able not only to reduce the size of the spleen, but also the number of leucocytes in the blood, both of which become almost normal. Such remissions are variable in duration, and the improvement cannot be regarded as permanent; however, it permits the recourse to surgical methods formerly prohibited by the tendency to hæmorrhage and the actual size of the viscus. At the Mayo Clinic the operative mortality under such preliminary treatment has fallen from 86 per cent. to 5 per cent. Twenty splenectomies have been undertaken for leukæmia, and, in some cases at least, the normal life expectancy in this disease has been considerably exceeded. W. J. Mayo's opinion that the operation in "selected cases should be further considered" is a restrained one, and may justly be taken as representing the present status of splenectomy for leukæmia.

Although congenital jaundice associated with splenomegaly had been previously described with splenoideas of chronic hæmolytic jaundice to Hayem, and to Minkowski. Although in other respects similar, the groups of cases studied by these observers differed in that, whereas in the latter's series a familial relation was clearly shown, the former's were acquired and not congenital.

The acquired (Hayem) form is the more serious, and apart from surgical treatment appears inevitably fatal. The symptoms of both types are—acholuric jaundice, *i.e.*, jaundice with unaltered stools and urine—enlargement of the spleen—and anæmia. Wasting is not rapid, and there is no itching of the skin. The red blood corpuscle count is reduced—the resistance to hypotonic salt solutions decreased and an increased number of reticulated red cells is observed. Here the picture of increased red cell destruction is clear; the reticulated red cells point to an output of "unfinished" erythrocytes, due to the anæmia, and the splenomegaly gives us an index to the organ at fault.

Whether the disease is primarily a splenic hyperactivity or a "fragility" of the red cells we do not at present know. In the Hayem type the disease demands prompt arrest; in the Minkowski form surgical interference is only required when the anæmia or weakness lead to constitutional disability.

In either case, splenectomy has proved to be a specific in this disease; the operative risk is slight and the results rapid and impressive. Within a few days the skin becomes clear and white, all symptoms disappear, and recurrence is not to be feared.

After splenectomy in this disease there is an *immediate* and rapid rise in both the red blood cell count and in the hæmoglobin. There is a noteworthy absence of the anæmia which occurs after other cases of removal of the spleen, and the usual leucocytosis does not appear—the white cell variation being small. In a case of Hitzrot's the resistance to hæmolysis was markedly increased; before operation, hæmolysis commenced in ·74 per cent. NaCl solution and was complete in ·58 per cent.; a few weeks after operation the figures were ·48 and ·30 respectively. Enumeration of nucleated and vital staining red corpuscles before operation disclosed a certain degree of precipitate red cell liberation. Immediately after operation the "young" cells were more numerous, but soon returned to a normal figure with the regaining of weight and strength by the patient.

The position of splenectomy in chronic hæmolytic jaundice may be regarded as firmly established—the persistence of red cell fragility after operation in Sir Spencer Wells' case is to be regarded as an isolated phenomenon, and, at any rate, seems to have no marked influence on health. In contradistinction to the results of animal experiments, although a large number of splenectomies have now been done in man, there seems no definite evidence that the incidence of infections is heavier on the splenectomised than the normal individual.

A large clinical group of cases, characterised by splenic enlargement and anæmia, and originally described as "splenic anæmia," is being gradually encroached on from all sides by more abundant knowledge of the pathological and etioligical factors, and the name splenic anæmia, or Banti's disease, is now applied to the unassimilable residue. Among the sub-groups are the following :—

Gaucher's disease—chronic endothelioma of the spleen—pathologically characterised by the presence in sections of cells $20\mu - 40\mu$ in size filling the alveoli; here diagnosis before removal is difficult, if not impossible; splenectomy has, however, been successfully carried out in a number of cases, a result somewhat surprising when one considers the reports of co-incident and similar affection of lymph glands, liver and bone marrow.

Infantile splenomegalic anæmia—another offspring of the "splenic anæmia" group—is characterised by a progressive anæmia occurring in young children and usually proceeding to a fatal issue before the child reaches two years of age. Here the splenic enlargement, coupled with the futility of recourse to therapeutic measures, led to the operative removal of the spleen. In the majority of cases the results have been satisfactory; in that reported by Wolff and Graff, however, the complete clinical syndrome returned one year later.

A case reported by Stillman (American Journ. Med. Science, February, 1917) under this heading would seem to be intermediate between this disease and the splenic anæmia of adults, as the child was nine years old. Here before operation the hæmoglobin percentage was 23, the red count 2,100,000, and hæmolysis was complete in ·44 per cent. NaCl. The improvement after splenectomy was rapid and sustained, and after nine months the hæmoglobin percentage was 80, the red cells 5 millions, and hæmolysis was not complete until 28 per cent. NaCl was reached. Here we have marked encouragement for surgical treatment, especially as other methods are of so little use.

The diseases which have received the names of *Vaquez* and of *Griesinger* seem insufficiently differentiated from other conditions with splenic enlargement; in Vaquez's disease splenectomy has been attempted without the expected amelioration; the identity of these diseases seems too nebulous to enable one to dogmatise on the correct treatment.

Concerning Banti's disease, it is difficult to obtain a clear clinical picture; the name has been loosely applied to all anæmias with splenic enlargement, and thus used as synonymous with splenic anæmia, in the wider sense of the latter term. Banti's criteria for the identification of the disease which bears his name are of little value in early cases. His three clinical stages—(1) Enlargement of the spleen and secondary anæmia, (2) Gradual increase in size of the liver with oliguria, and (3) Atrophic cirrhosis of the liver and ascites—do not help in early diagnosis, while his pathological descriptions are of use only in the correct completion of the death certificate. Banti considers the disease infective in origin, and here must be remembered the mycelium demonstrated by Gibson of Oxford in the spleens of several cases; other observers have been unable to agree with his results, and Moynihan indeed, restricts the term "splenic anæmia," used here as a synonym for Banti's disease, to cases of which the etiology is unknown.

The anæmia and cirrhosis are considered to arise from the splenic infection, and to the cirrhosis are traceable the hæmorrhages which are so marked in the later clinical pirture. In view of the pathology outlined above, it will be seen that the only treatment for splenic anæmia is splenectomy. Operation should be performed as early as possible, preferably before the onset of stage (2) above, although even in later cases much improvement often follows.

Blood transfusion is, of course, an important pre-operative measure in cases who have had considerable hæmorrhage, and X-ray applications may bring an extremely large spleen down to a bulk appropriate for removal. In this disease, particularly in advanced cases, the tendency to perisplenic adhesions is marked and the operative mortality is thereby increased. Still it should be borne in mind that the unhealed disease is *inevitably* fatal in outcome.

After splenectomy the red cell count and hæmoglobin percentage—which in some cases are extremely low—rise to normal at first rapidly, then more slowly and the individual regains strength. The post-operative leucocytosis is less marked than in the normal individual and the increased resistance of the red cells to hæmolysis is slight.

In a case of splenic anæmia (under Dr. Shaw, in 1916) from which a spleen four times the normal size was removed, at operation—the blood, three weeks after operation already showed an increase of over half-a-million red corpuscles per cubic millimeter associated with a somewhat less rise in hæmoglobin. Here, too, a pre-operative white count of 2,000—2,720 became, three weeks after the operation, 8,440 per cubic millimeter. The red and white

cell count were normal when the patient was seen in 1920.

In the post-mortem investigation of cases of pernicious anæmia the demonstration of excess of iron pigment in the spleen and liver is often very striking. In some cases of pernicious anæmia the spleen is enlarged. These two factors led to suspicion of the spleen, and three workers independently advocated splenectomy in this disease, all of them essentially basing their advice on the diminished hæmolysis resulting from splenectomy. The results at first were disappointing, the operative mortality was high, post-operative complications frequent, and the resulting improvement not sustained. At the present day it appears that idiopathic pernicious anæmias can be divided broadly into two groups—(a) those with deficiency of red cell formation, aplastic cases, which splenectomy cannot be expected to benefit, and (b) those with excessive blood destruction, in which removal of one hæmocatatonic organ, the spleen, might well yield improvement.

The distinction between the two classes is difficult: if, however, in the patient's blood there is evidence of liberation of immature red corpuscles—if "vital staining" cells are present in more than normal proportions—the disease is probably of the hæmolytic and not the aplastic type.

Modern opinion, as exemplified by the Mayo technique, advises three main steps—(a) massive blood transfusions directed toward bringing the red cell count and hæmoglobin as near as possible to normal, (b) removal of possible or probable infective foci, and (c) splenectomy. The relative value of these three factors is disputed, the improvement often resulting from attention to (a) and (b) above is well known, and the apparently causeless remissions in the course of the untreated disease render it more difficult to appreciate the value of any one step. The Mayo Clinic results so far are inconclusive; it appears unlikely that splenectomy will *cure* pernicious anæmia, but in some cases at least the remissions of the disease seem longer, and the period of life exceeds the normal expectancy.

Hitzrot describes a case of marked anæmia with high colour index in whom splenectomy gave rise to an immediate improvement in hæmoglobin and in red cell count, and in whom, certainly with the aid of a small blood transfusion, the blood picture was normal after six months, the patient felt perfectly well, and had gained 37 lbs. in weight.

Such a result is too satisfactory, and in the lack of confirmatory evidence must cast some doubt on the diagnosis of pernicious anæmia.

To summarise, splenectomy would seem to be clearly indicated in:—

1. Splenic anæmia (Banti's disease) especially in the early stages.

2. In both the familial and acquired types of hæmolytic jaundice.

3. In infective conditions, in which the general infection is slight or controlled by ordinary means, but in which the infective process seems so firmly lodged in the spleen as to resist medical treatment. Such conditions are found in some cases of malaria, tubercle, syphilis and sepsis.

4. In neoplastic conditions of the spleen, cysts (parasitic or otherwise), and in displacements.

In the following, the main argument in favour of splenectomy is the futility of other lines of treatment, rather than the response of the condition to operation.

1. Pernicious anæmia.

2. Gaucher's disease.

3. Infantile splenomegalic anæmia—this may, indeed, deserve a place in the group above.

In the splenomegaly of leukæmia, and of Kala Azar, operative treatment has yet to prove its value—present day preliminary treatment has obviated the immediate mortality so terrifying in the past in the former disease, but recovery is not yet the rule.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

The War Memorial.

SIR,—Like Dr. Ryle I much dislike the "final" selection of the wording to be inscribed—but for different reasons.

The Memorial is a "War Memorial," not "War-dead males, Memorial." The Memorial is to the "Effort" made by those of Guy's—men, and no less the women!

The Memorial should be to the "Glory of those of Guy's who did their part," and to "the Honoured memory of those who fell in doing so."

I firmly believe that those whose names are inscribed would wish it to be so, for its presence will be an *inspiration and an example of the spirit of sacrifice* for a noble cause to those who are future generations of Guy's students: yea, and to the nurses, too.

Tombstones with their customary wording are *dead* things. How little do monuments to the dead of former wars give any feeling of inspiration when one reads them? The Editorial matter in the GAZETTE seems to me to miss the point of "life," and favours the conventional recording of the "dead."—Yours faithfully,

ASTLEY V. CLARKE.

19, Victoria Road,
Leicester.

Sir,—I am not surprised at the tone of Dr. Ryle's letter to the Gazette of April 2nd concerning the proposed inscription for the War Memorial, viz., "To the Honour of those who came through. To the Memory of those who died." What honour is due to any Guy's man for Not having been killed in the War?

He had—and has—the honour of knowing that he played a manly part in the war, as a Guy's man would. This honour is intrinsically his, and will not tolerate any such proposed recognition, above the names of his dead brethren, upon the Memorial. The spirit which prompted their Alma Mater to raise this Memorial Arch was to honour the memory of her dead sons, killed in the war, in their Country's cause. This is how all Guy's men must feel who have suffered the anguish of having lost one or more boys in the war.

Upon this Memorial Arch the grief of such losses will not tolerate the intrusion of the living.—I am, Sir, yours faithfully,

3rd April, 1921. Wm. LANSDALE.

The Results of Reconstruction.

Sir,—The shadows of war conditions have now passed away sufficiently to enable those who remember Guy's before the war to compare it with Guy's as it is to-day, as far as the training of the student is concerned. The period of reconstruction has passed, and those who remember conditions previous to the war are now beginning to ask themselves whether all the time and energy expended by reconstruction committees have augmented or diminished the facilities for training students.

Even the most conservative must admit that in some directions there has been an improvement. For example, the new scheme of appointments ensures that every extern who goes out to his work on the District shall have had previous experience in the wards. Further, there has been an increase in the facilities for study among senior students and qualified men.

On the other hand, there are several points in the new arrangement of appointments which are open to criticism. Although in theory the unit system may seem desirable enough, it must be admitted that the pre-war appointment of Assistant Surgeons' Dressers as Clerks to Medical Out-Patients served a useful purpose in forming a link between the two medical appointments. Again, what has been the effect of Out-Patients in the mornings instead of in the afternoons, as far as students are concerned? Before the war a keen clerk could spend an hour and a half writing up the histories and examining the new patients before the arrival of the Assistant Physician or Surgeon. With Out-Patients beginning at 9.30 a.m., he does not now get this valuable opportunity of making up his own mind about a case. In its place he must be content with seeing the case demonstrated by others.

But there is another and more general criticism which can be brought against the methods of to-day. Before the war, Guy's had the reputation of giving its students the best practical training of any Medical School in the country, if not in the world. To-day there seems to be a tendency among students to set more store by attendance at lectures, classes and demonstrations than by the study of individual cases in the wards. Worse still the ward appointments are tending to become less responsible positions. Before the war nearly every Surgeon's Dresser made a point of living at the Hospital. To-day comparatively few do so, perhaps owing to the number of junior men who live in College. Then, again, before the war it was relatively infrequent to see a House Surgeon dressing to a Surgeon at an operation. This was always regarded as the prerogative of the dresser to the case, and unless the House Surgeon himself was doing the operation, he did not wash up. In these days of large firms it is surely more important than ever that the dressers should have the opportunity of assisting the surgeon.

I will close with one more point about the P.M. arrrangements. Before the war, P.M. commonly started at 1.30 p.m. instead of 2.0 p.m., or even 2.30 p.m., as they do to-day. The later hour deprives ward clerks of the opportunity of putting in half an hour studying morbid anatomy without in any way interfering with their afternoon's work.—I am, Sir, yours, etc.,

PROGRESS NOT CHANGE.

Guy's Hospital,
S.E. 1.
April 11th, 1921.

Herpes and Varicella.

Dear Mr. Editor,—In view of the fact that recently, articles and correspondence have appeared in various medical journals on the topic of the association of herpes and chicken pox, I thought perhaps, that a case of mine might be of sufficient interest to your readers for you to publish it in the Gazette.

Mr. G., aged 56 years, has for some weeks past been suffering with furunculosis of his face, neck and scalp.

On Sunday, March 13th, I found that he was suffering from an extensive herpes of the left side of his scalp, face and neck. I sent him to see Dr. H. W. Barber who confirmed my diagnosis and suggested treatment.

The interesting sequel is that Mr. G.'s son (aged 24 years) developed chicken pox on March 30th

(*i.e.* 17 days after his father started herpes). I could find no evidence that he had been in contact with any case of chicken pox. Taking into consideration these recently published cases, surely there must be more than pure coincidence in the association of herpes and chicken pox in this case of mine.

I might add that my two partners have each had a case, but I am unfortunately unable to verify certain facts such as dates.—Yours truly,

R. SELLS.

Crinnis House,
Southend-on-Sea.
April 7th, 1921.

The Business Side of Medical Practice.

Sir,—One reads much in the medical papers and the Gazette about the reform of medical education. There is one not altogether unimportant subject—at present entirely disregarded—with which it seems to me every student should at least be acquainted when he is turned out as a qualified medical man. I refer to the business side of medicine. The majority of students are going to be general practitioners, and as such are going to earn their daily bread by doing jobs which in hospital they regarded as somewhat beneath them and probably endeavoured to push on to someone else. General practice is largely analogous to medical outpatients, and here let me remark that the keen student will learn more medicine and surgery in out-patients and the surgery than in any other department of the hospital.

When a man comes to leave the hospital he is in many cases as wise as a serpent in his professional knowledge, and as innocent as a lamb of the business side of the practice of his profession. He proceeds to hunt for a practice and investigates many, good bad and indifferent. He knows very little or nothing of the market value of medical practices, and unless he has someone with experience to hold him by the hand he stands a very decent chance of being badly let down, for the doctor selling a share of a practice—in common with most people with something to sell—is not a philanthropist.—I am, Sir, Yours, etc.,

EX-RESIDENT.

Papers by Guy's Men.

D. W. Samways, M.D., D.Sc., M.R.C.P. Cardiac Peristalsis and Mental Stenosis.—*British Medical Journal*, April 2nd, 1921, p. 490.

F. D. Saner, M.B., B.C., F.R.C.S. Three Cases of Diverticulitis of the Colon.—*Practitioner*, cvi. p. 276.

J. Lewin Payne, L.R.C.P., M.R.C.S., L.D.S. An Artificial Velum for Congenital Cleft Palate.—*Dental Record*, xli., p. 150.

T. B. Layton, D.S.O., M.S., F.R.C.S. A Clinical Lecture on When to Open the Mastoid Antrum in Antrum in Acute Ear Disease. Delivered at Guy's Hospital, February 28th, 1921.—*Lancet*, April 19th, 1921, p. 734.

Obituary.

David M. Beddoe, F.R.C.S.

This appreciation of the work of Dr. Beddoe is reprinted from a Cairo paper, *The Sphinx*.

Dr. David M. Beddoe, F.R.C.S., whose death last Sunday cast a gloom over the English community in Cairo, is missed not only by his mother and sister—he died a bachelor—but also by a wide circle of friends, many of whom had at one time or other been patients of his. A prominent member of the Cairo community, who was intimately acquainted with the deceased gentleman, has been kind enough to furnish us with the following brief but eloquent tribute to his memory:—

"With the death of Dr. Beddoe, Cairo has lost not only one of its most able and kindly physicians; but most of us have lost a very dear and valued friend. Doubtless his devotion to his work cost him his life, for his own personal comfort was never considered when a call was made upon him. His deep sense of humour, added to his ready and spontaneous sympathy, pulled many of us through dark moments. He possessed brilliant literary ability, and had he not spent his life alleviating pain he would surely have won a high niche in the world of letters. His varied and deep knowledge, his habit of observation, and his unfailing tact and geniality made him a most delightful companion. We feel that with him goes some of the brightness of our lives."

His Career.

Dr. David M. Beddoe was the son of William Beddoe, solicitor, of Merthyr Tydfil (Glamorganshire), where he was born in 1870. He was educated at Brecon College, and studied medicine at Guy's Hospital, where he qualified and took his degree with honours as F.R.C.S. (England), becoming a noted throat specialist. Shortly after he had qualified he was appointed resident doctor at Newport Hospital, where he contracted a severe illness, which necessitated his going to live in a warm climate. In due course he visited Egypt, and as the outbreak of the South African War had created a shortage of doctors in Cairo, he worked for some time for the Army at the Citadel. Dr. Beddoe then took up practice in Cairo as a general practitioner and soon made his mark. For many years he was examiner in surgery at Kasr-el-Aini Hospital, but latterly had had to relinquish this post owing to the calls made on his time by his large practice. During his leisure he devoted himself to literary work. Quite a number of short stories from his pen have appeared in the English magazines and he published two novels, "The Honour of Henri de Valois" and "The Last of the Mamelukes," both of which were instant successes. At the time of his death two new novels, which had been accepted by his publishers, were being revised by him.

Clinical Demonstration at Lambeth Infirmary.

Gout and Myxœdema.—William Robert S., æt. 58. Started 20 years ago in his great toe joint and he has had frequent attacks since.

Gout.—Frederick P., æt. 63. Numerous attacks of acute gout for last 20 years.

Gout.—Thomas William P., æt. 56. First trouble started in his feet 16 years ago, and then no trouble until 18 months ago.

Atrophic Rheumatoid Arthritis.—Mary Ann M., æt. 69. Commenced about six years ago in knee joints. Later started in joints of fingers.

Hypertrophic Rheumatoid Arthritis.—Jessie T., æt. 37. Commenced 14 years ago in joints of toes, then in knees, and later in fingers and wrists.

Hypertrophic Rheumatoid Arthritis.—Harriet Annie A., æt. 58. Commenced two years ago in joints of toes; later spread to fingers and then knees.

Gout.—Minnie W.

Rheumatoid Arthritis.—Ellen B., æt. 64. Patient has been bedridden for about 36 years—very advanced condition.

Infective Arthritis.—Harry William W., æt. 42. Gonorrhœa 25 years ago and joints have been bad since then. Patient shows extreme deformity and ankylosis of most of his joints.

Infective Arthritis.—John M., æt. 48. Started with an acute polyarthritis 8 years ago. Patient shows swelling and partial ankylosis of his joints. Severe pyorrhœa, possibly source of infection.

Osteo-arthritis of Hips.—Harry L., æt. 64. Slowly increasing disability from pain in hip joints for 12 years. His attention was first called to condition by an injury and has been slowly getting worse. He has early paralysis agitans.

Osteo-arthritis of Right Hip.—George K., æt. 68. Patient has severe osteo-arthritis, right hip being joint most affected, and several of his joints show the typical changes.

Tabes Dorsalis—Charcot Knee.—Thomas B., æt. 54.

Tabes Dorsalis—Charcot Knee.—Lucy L., æt. 56.

Recurrent Carcinoma Mammæ.—Elizabeth G., æt. 63. Patient is complaining of pain in left femur, and although X-rays do not show any changes in the bone, it is probable there are secondary deposits in the subtrochanteric region.

Gangrene of Foot.—John H., æt. 55. Dry gangrene of left foot 5 years ago. Amputation through thigh. Dry gangrene of right big toe last April for which arterio-venous anastomosis was performed at a hospital.

Gangrene of Foot.—Edward F., æt. 78. A dry gangrene of foot due to thrombosis of the femoral artery.

Raynaud's Disease.—Walter C., æt. 58. Patient shows the atrophic changes of the fingers and at different times ischæmia and enlargement of the fingers.

Freidreich's Ataxy.—David P., æt. 26. One brother had similar disease and died, æt. 10. Patient shows an advanced stage of the disease and is beginning to exhibit symptoms of bulbar paralysis.

Spondylitis.—William A., æt. 39. About 8 years ago he had double pneumonia and he dates the bending of his spine from then. He now has pulmonary tuberculosis.

Spontaneous fracture of Femur.—Henry W., æt. 68. Started having fits when 62 years; the fits are "Jacksonian" in character. He has left hemiparesis and a spontaneous fracture of femur, and X-ray appearance suggests an endosteal growth? cerebral tumour with secondary deposits in his femur.

Pulmonary Tuberculosis and Splenomegaly.—Sarah G., æt. 37. Patient has advanced tubercle of lung. Liver and spleen both enlarged and hard. There is not any œdema and no albumin in the urine.

Secondary Carcinoma of Liver.—Henry C., æt. 59. Primary carcinoma not yet ascertained, but probably rectum.

Change of Address.

Christopher Dean, Kimbolton, Hunts.

Arthur Thomas, Surgeon Commander, R.N., H.M.S. *Sandhurst*, Devonport.

V. A. Luna, 17, Bentinck Street, Cavendish Sq., W 1. Telephone 2890 Mayfair.

G. Kidman, 123, Osmaston Road, Derby.

A. E. Sawday, 123, Osmaston Road, Derby.

Stephen Coffin, 63, Wimpole Street, W. 1. Telephone, Langham 1910 (after 5 p.m., Paddington 1456).

Eliot Blake, Oakley House, Acle, Norfolk. Telephone 6 Acle.

Oswald G. Morgan, M.Ch., F.R.C.S., Royal London Ophthalmic Hospital, City Road, E.C.

Notices.

Sir William Hale-White will give a lecture on "What Medicine Owes to Bright," at 12 noon on Friday, April 22nd, in the Anatomical Theatre.

Guy's '89 Club.

The Twenty-sixth Annual Meeting and Dinner of the Club has been arranged to take place at Hotel Cecil, Strand, on Wednesday, May 11th, at 7.30 p.m., Dr. J. A. Howard, President, in the Chair. Members are requested to note the date and place of the event pending receipt of notice from H. J. Spon, Secretary, 61, Harley St., W. Langham 2712.

The Summer School of Civics.

The Summer School of Civics, organised by the Civic Education League, is to be held this year at Guildford, Surrey, from 30th July to 14th August. The Local Education Authority at Guildford, and the Surrey Education Committee, are co-operating by placing accommodation at the disposal of the School, which will also have the advice and assistance of a local Committee. The organisation at the League Headquarters will be in the hands of the Committee responsible for last year's school, with some additions, the Chairman being, as formerly, Mr. Alexander Farquharson.

The programme of studies is being extended and enlarged, as a result of last year's experience, and will give students opportunities of getting into touch with recent developments in nearly every department of Social Science. The promotion of good citizenship through every educational means is the central aim of the school; but the attempt will be throughout to relate every branch of social study to this aim. Courses on Economics, Anthropology, Social Biology, Maternity and Child Welfare, Sociology, Civics and Social Psychology will be among those offered; while practical training in the presentation of Civics (through Public Speaking, etc.) and in the Regional approach to Civics will also be provided. In connection with the latter plans are being made for a detailed survey of Guildford and its region especially in their social and economic aspects, both present day and historical.

The courses will be adapted to the needs of Training College Lecturers, teachers in Elementary, Secondary and Day Continuation Schools, Social Workers (including Health Workers), lecturers on Citizenship and other social topics, Organisers and social students.

Full particulars may be had from the Secretary, Miss Margaret Tatton, Leplay House, 65, Belgrave Road, S.W. 1.

Pass List.

University of London.

Second Examination for Medical Degrees.
Part I. March, 1921.

C. B. Andrae.
L. Bechal.
P. C. Bennison.
H. E. Blake.
M. F. Butler.
G. Davies.
S. C. Davison.
F. R. Dingle.
A. W. Riddolls.
G. R. Ford.
H. J. Fuller.
A. S. Gough.
D. S. Huskisson.
W. G. Roberts.
M. H. Jacobs.
R. A. Nash.
R. G. Nethery.
H. L. Peake.
W. F. Roper.
H. J. Selby.
D. A. Skan.
I. P. Spurrell.
H. K. Williams.
R. G. Williams.
J. C. Young.
A. B. Plant.

L.D.S.

Final Examination. February, 1921.

*L. Harley.
*H. J. Barrand.
*J. Broude.
*H. C. Churchill.
*P. N. C. Conway-Jones.
*A. B. Daneel.
*D. J. du Buisson.
*J. I. de Villiers.
*D. C. Eglinton.
*L. W. Elmer.
*F. J. Farmer.
*W. M. K. Gray.
*C. R. Hardwicke.
*F. R. Hogbin.
*O. F. A. Krause.
*J. Lanchester.
*J. A. Krige.
*A. S. Landsler.
*T. E. Brevetor.
*J. Levy.
*S. Levinson.
*M. Lewis.
*O. D. Morris.
*O. T. R. Painter.
*G. E. Price.
*G. P. Pritchard.
*W. E. Silver.
*J. S. Smith.
*F. W. Van der Hoven.
*P. J. Walters.
*O. G. Morris.
G. R. D. Bradfield.
E. Clark.
F. W. Day.
L. F. Fouraker.
F. D. Gratrix.
A. L. Hyslop.
P. Krige.
W. A. Krige.
G. K. Moore.
R. A. Moore.
F. J. Myers.
F. D. Neal.
H. K. Price.
F. W. Stiven.
G. M. Stuart.
W. A. Turner.
C. P. M. Valette.
J. W. E. Warren.
H. C. Tweney.

*Part I. only

Appointments.

Guy's Hospital Medical School.

April 16th—July 15th, 1921.

Surgical Ward Clerk.—Messrs. T. S. Blacklidge, W. A. Caldwell, R. S. Chambers, A. R. Cox, A. S. M. Douglas, G. F. Gibberd, C. W. Greenway, L. G. Housden, D. J. Jeans, R. R. Mackintosh, G. O. Mitchell, Millis, P. Mc. G. Moffatt, E. E. Neser, F. N. Newell-Roberts, G. W. Owen, G. W. V. Parry, A. T. W. Powell, S. C. Rowbotham, M. Seng, H. C. C. Taylor, D. Vaughan, R. Waterfield.

Clerks to Medical Unit (first three months).—Messrs. R. H. Amm, M. Bannounah, C. G. Bowen, H. G. R. Canning, N. L. Eckhoff, J. L. Faull, F. E. Graham-Bonnalie, H. Hawke, D. B. Hitchings, N. L. Lloyd, M. Mitman, M. Myers, H. Seelenfreund, G. D. Shaw, R. G. Tame, T. Wooldridge, Killard-Leavey and G. T. Henderson.

(Second three months).—(Dr. Fawcett, Dr. Ryle and Dr. Marshall) Messrs. F. J. Biddle, G. E. Fisher, M. Jackson, G. M. Stoker, H. J. F. Wood, C. H. Atkinson, V. De Boissier, M. Markiles; (Dr. French and Dr. Poulton) Messrs. D. Crawshaw, G. R. Apsey, C. A. Probert, S. C. Bakhle, A. W. Hall, F. R. Ratnagar, J. Atkin; (Dr. Hurst and Dr. Hunt) Messrs. D. Davies, H. Beccle, E. Koerner, D. Whitlock, L. Forman, M. Honigsberger, J. Linklater.

Dressers to Surgical Unit (first three months).—(Sir A. Fripp and Mr. Turner) Messrs. A. Gordon, R. Still, F. Smith, I. Harries, G. Withers, W. G. Booth, A. Broido; (Mr. Steward and Mr. Hughes) Messrs. J. Lloyd, Plowright, R. Brooke, Denyssen.

A. Aldred, Meathrel, A. Percy; (Mr. Fagge and Mr. Davies-Colley) Messrs. W. Brown, C. Carson, D. H. Hubbs, H. Evans, H. Bernstein, D. Robinson; (Mr. Rowlands, Mr. Bromley and Mr. Slesinger) Messrs. H. Harvey, C. W. Warne, Woodhouse, P. Hack, S. Suzman, E. Orsmond, M. Weinbren, S. Daneel, H. Croucher, R. J. Hooker.

(Second three months).—(Sir A. Fripp and Mr. Turner) Messrs. D. A. Windemer, H. T. Chiswell, L. H. B. McLeod, C. C. Po; (Mr. Steward and Mr. Hughes) Messrs. W. G. R. Hore, P. G. Sedgwick, B. C. Woodroffe; (Mr. Fagge and Mr. Davies-Colley) Messrs. C. L. Kark, W. M. Ramsden, C. F. Parry, C. A. Marais; (Mr. Rowlands, Mr. Bromley and Mr. Slesinger) Messrs. R. Hale-White, F. D. Howitt, J. S. Hudson, D. G. Sharp.

Obstetric Dressers, Extern, and Clerks in Children's Department.—(Mr. Bellingham Smith) Messrs. I. J. Bechal, H. B. Flooks, J. R. Herbert, H. Richards H. K. Wallace, J. F. Payan; (Mr. Chapple) Messrs. H. A. Harris, M. M. Hegab, B. L. Laver, M. Mackenzie, F. W. Widgery.

Dressers in Special Departments—

Ophthalmology.—(Mr. Eason) Messrs. M. W. Mackeith, H. Taylor; (Mr. Ormond) Messrs. J. Alexander, G. Curson.

Laryngology.—(Mr. Layton) Messrs. I. B. McCann, H. W. Taylor and C. Shepherd; (Mr. Mollison) Messrs. F. Bekker, J. Alexander, and R. J. Hodgkinson.

Dermatology.—Messrs. G. C. Curson, C. Shepherd, T. E. Jones, A. T. Rogers, A. Douthwaite, E. H. Richards.

Neurology.—Messrs. R. J. Hodgkinson, I. McCann, M. Mackeith.

Orthopædics.—Messrs. F. Bekker, E. H. Richards, J. K. Milward.

Pathological Assistant to the Demonstrators of Morbid Anatomy.—Mr. S. C. Bakhle.

Clinical Assistants.—Messrs. S. Annecke, G. W. Elkington, J. B. Gregor, A. H. Shelswell, K. K. Watson.

Dr. G. Dunderdale, M.D., B.S.Lond., to be Hon. Visiting Physician to Grey's Hospital, Pietermaritzburg, Natal.

Reviews.

Outlines of Zoology. By Professor Thomson. Oxford Medical Publications. Price 18/- net.

Striking and admirable features of the book we have before us (v.s.) are the number, accuracy and clearness of the classifications, which are peculiarly essential to the clear and wide comprehension of that greatest of matters mundane—animal life. The system of classification which is adhered to, throughout the work, reduces zoology, which tends otherwise to be an inchoate mass of facts and theories, and indeed, can never be an exact science, to an almost concise subject.

The one great danger at classification, that of giving a false impression of the completeness of the subject, is, moreover, avoided as we are constantly reminded throughout of the large gaps in our knowledge, some of which no research can fill. The system of giving a brief, simply worded and copiously illustrated survey of the animal kingdom for the student to commence upon is wholly admirable and will be greatly appreciated, even by senior students, who, in their more minute study of detail may have lost the broad outlines of the subject.

Professor Thomson is, perhaps, the most readable of our scientific writers and he manages to infuse into his work, by popular reference and pleasant diction, a degree of that charm of which Henri Fabre is the Master.

This power, when in combination with a classified and well ordered treatment of the subject is as gratifying to the reader as it is rare in scientific works, and for the entire volume, excepting some of the diagrams, such as Fig. 26, which are obscure on account of their minuteness and bad execution, we have naught but unstinted praise.

Football.

RUGBY.

GUY'S v. COVENTRY.

This, the last First XV. match of the season was played at Coventry on Saturday, April 2nd. Below full strength, we still managed to make a draw of it—2 goals and 1 try each. Not having the full pack out made a great difference, but those that did duty were jolly good substitutes and much credit should go to Neser, Taylor and Biddle. Behind the scrum we had a pull and Van Heerden at full back gave a very sound display. One must congratulate Bekker, Steyn and Van Schalkwijk on being perpetually ready to play for the Hospital. Their keenness is a great example to others, for many times one knows, they could have done with a rest, but felt that the Hospital's credit was in their hands.

Coventry were the first to score, the try was unconverted and this was all the points the first half brought.

Rose again scored for Coventry soon after the resumption and this time the try was converted. Eight points against us—and this adverse number might easily have been more if Van Heerden hadn't been in really excellent form at full back.

Guy's now began to tackle their job in real earnest and Taylor managed to gain 3 points right in the corner. But after this temporary success Coventry gained another try, Gilbert being the try getter and Morris converted—Ten clear points and not very long to go. Guy's never gave up and Sprong and Steyn going splendidly got us a try each. Van Schalkwijk and Steyn respectively goaling and thus bringing the scores level—13 points all.

Guy's Team.—H. Van Heerden, C. L. Steyn, P. K. Albertijn, J. G. Schalkwijk, A. J. Osmond, E. L. Sprong, F. Bekker, E. E. Neser, W. H. Taylor, G. Zondagh, L. B. Helder, C. Harvey, Cockes, H. Hutchinson.

The curtain is now down and nothing but rumination left. The same can be said of the 1920—21 XV. as of its predecessor. The XV. was a great one, with tremendous scoring ability, they were a source of great attraction and showed wonderful form on occasions. The brace of defeats from Cambridge was surprising. Matches played 26; won 18, drawn 2, lost 6. The best win was against Gloucester.

W. D. Doherty proved himself, for the second year in succession, a great Captain. G. E. Kidman was missed from the pack and it was a sad fact that H. Graham-Davies and J. A. Krige were absent from many matches owing to injuries. That plucky sportsman, P. J. Krige, was totally prevented by his illness of last summer from playing at all.

P. K. Albertijn, W. H. Taylor, and A. Daneel, were new comers to the final. Of the first named one has scarcely yet, I believe, seen the best he can do. Taylor is a splendid forward, and Daneel the most improved player at the Hospital. R. F. H. Duncan, as Hon. Sec., has proved a worthy successor to his many great predecessors, and the fixture list he has arranged for next season makes one long for the good games in store for us as soon as Autumn arrives.

THE JUNIOR INTER-HOSPITAL CUP.

The "A" XV. are to be congratulated upon retaining this Cup, which has remained with us ever since it was first played for in 1905, except for the two years 1906 and 1907.

Guy's reached the semi-final unopposed and the final stage by defeating St. Thomas's in a very vigorous game by 23 points to nil, but in spite of the score this was a tougher match than the final with Bart.'s.

The final, like the semi-final, was played at Chiswick. After a few minutes' play Hirschburg opened the score for us, but it was some time before a further score was made. Many promising movements were spoilt by faulty handling of the light ball and overcrowding on the touch line. At one period it seemed as though Bart.'s forwards were the better, but Biddle led his men well, and before half time our pack had the measure of their opponents and our 3 point lead was increased.

In the second half Bart.'s were several times very dangerous, but only managed to score once, their left wing intercepting at half-way and running clean through our defence. With a cleverer set of backs and the forwards getting frequent possession it is not surprising that Bart.'s were beaten by 21 points to 3 points.

Hockey.

GUY'S v. ST. THOMAS'S.

Final of Inter-Hospital Cup.

It is very much to be regretted that we did not follow the example of the "Rugger" and "Soccer" teams by winning the Hockey Cup this year, but that the team, after a successful season, reached the final stage after accounting for the holders in the first round, reflects credit on all concerned.

The final was played at Richmond Athletic Ground on Friday, March 18th. Play was level in the first half, and although Schollum strained his leg early in the game, and was more or less incapacitated, we had our full share of the game, H. Slaughter, of St. Thomas's, scoring the only goal.

In the second half our opponents, who were playing well together, asserted their superiority, Slaughter adding two more goals, Walters one, and Thomson scoring from a beautiful run from his own "25." Our forwards were unable to penetrate the sound defence put up by Philipps and Crockford; the latter played an extraordinarily sound game. Baugh, our goalkeeper, effected some good saves, but he was very poorly supported by his backs; the halves were no more than ordinary, with the exception of Slater who was one of the few who distinguished themselves, and the forwards were disorganised by Schollum's injury. Owen and Bonnalie did some nice work, and looked like scoring, especially during the first half, and Tonkin worked very hard, but it must be admitted, our opponent's backs were too good to be penetrated by any of their rushes.

We were thus soundly beaten by 5 goals to 0, and if the defeat was greater than it should have been, there is no doubt that St. Thomas's were the better team. The game was well umpired by Mr. Hunt and Major Andrews, of the S.C.H.U.A. An encouraging sign of the popularity of the game in the Hospital was the number of Guy's men on the touch line among whom we were very pleased to see two of our Vice-Presidents, Messrs. Fagge and Bromley.

Last season we did not survive the first round, so that the improvement is evident, and provided that we get that support which the game deserves, we should go one stage further next year and add to the collection in the "Spit."

Guy's Team.—C. T. V. Baugh; C. G. Bowen, W. F. Hurdle; A. L. Mackay, K. Hooper, H. Slater, W. S. Hunt, J. W. Schollum, B. M. Tonkin (capt.), F. E. Graham-Bonnalie, and L. E. Owen.

Record for Season 1920—1921:—

1st XI.—Played 22; won 12, lost 8, drawn 2; goals for 91, against 65.

2nd and "A" XI.'s.—Played 21; won 10, lost 8, drawn 3; goals for 91, against 66.

Marriage.

SHACKLOCK—THOMSON.—On March 24th, at Southwark, by the Rev. H. Maynard, George Augustus Shelmerdine Shacklock, M.R.C.S., L.R.C.P., eldest son of George A. Shacklock, Esq., of Mansfield, to Gertrude Beves Thomson, third daughter of George Thomson, Esq., J.P., of Huddersfield.

Ed.—A. T. R.

GUY'S HOSPITAL GAZETTE.

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Passim.

OUR attention has been called to the number of Out-Patients who daily walk across the quadrangle on their way either to the Massage or Dental Departments or to Out-Patients only to be turned back by the porter at the Front Lodge and sent round to one of the Maze Pond entrances. Perhaps this may be no great trouble for someone with pyorrhœa or carious teeth, perhaps even he is glad of these few minutes respite which are granted him before he meets his inquisitor, but for some of the unfortunate patients who are dragging themselves on sticks or crutches massage-wards, this added journey of about two hundred yards is a very real trial. The suggestions made are—either that a more conspicuous notice shall be erected in St. Thomas's Street pointing out that all Out-patients must seek admission in Maze Pond, or that patients having crossed the quadrangle and clambered up the steps to the lodge shall be allowed to proceed by the nearest route to their destination. Surely we are all sufficiently democratic not to object to allowing these less fortunate, crippled, patients the ungrudging right-of-way through the Colonnade and the Park. Now that the new Massage Department has arisen in all its grandeur we must anticipate an even greater attendance than that which the old department had to cope with. We hope that some provision will be made to save these new patients the fruitless journeys so often made by their predecessors.

BEFORE this GAZETTE appears the War Memorial Committee will have met again to consider the protests which have been made against the inscription which they chose. We trust that they will see the justice of the storm which they raised and will see fit to choose some more fitting and more beautiful phrase. We are still receiving suggestions from our readers offering alternative inscriptions, some of which we publish in the correspondence columns of this number of the GAZETTE. No serious objections have yet been made to the words which were proposed in "Passim" some weeks ago, but the Honourable Evelyn Hubbard (a Governor of the Hospital) has written suggesting that the most concise and most appropriate inscription would be "Invictis Pax." These words he suggests might be used as a prefix to the phrase which we prefer, "Their name liveth for evermore." The first objection which we make to his proposal is that his inscription is in Latin, for we have advocated throughout that whatever we write on our Memorial should be written in our mother-tongue. We would

prefer to see the sentiment of his phrase expressed in English. This, however, would destroy one of its chief merits, namely, its conciseness, but this conciseness is similarly lost if we use these words, as is suggested, merely as a prefix, and we would submit that little is gained by so prefixing the original inscription.

A quotation which occurs in line 664 of the Æneid (book vi.) has also been suggested as appropriate in that it emphasises the work done by the medical units, to which so many of the Guy's men that were lost belonged. Conington translates this quotation thus:—

> To "all who grateful memory won
> By services to others done."

We would commend to our readers this quotation and also the one quoted in our correspondence columns from the "Enchanter's Nightshade," but we still venture to prefer the simplicity of "Their name liveth for evermore."

On page 175 we publish an appeal from the Secretaries of the Athletic Club for entries for the University of London Sports which are to be held at Queen's Club on May 25th. Last year we succeeded in equalling King's College and so tied for the possession of the "Rosebery" Cup. This year we must win, and we must win by no narrow margin. We are well able to do this if only we get a large entry of trained men. As the Athletic Club Secretaries point out, men must not be put off because they think that the sprints will be won easily by Steyn or the three miles by Housden, but they must remember that points are also gained by the second and third men. Then, again, there are the fields events such as putting the hammer or the weights, and the jumps. Men that know anything at all about any of these events will surely be able, with constant practice between now and the 25th May, to ensure the Hospital of a few points more towards the final victory.

Last year we won the tug-of-war with a scratch team picked up on the ground, which had never practised together, and most of whom knew little of the technique of tugging. Surely we could get together a heavy, strong team well before the day of the sports and, matching them against a practice eight, get them so well trained that they will be able to make the tug-of-war a certain victory for us. There is no reason why we should not have a team strong enough to emulate the team of 1906—09, which during these years carried all before it. However, no matter in what branch of athletics you may excel, or may hope to excel, practise it assiduously with an eye not only for fame in the University Sports, but also in the Hospital and Inter-Hospital Sports.

The coal strike still continues and shows no signs of a speedy conclusion. Here at the Hospital, although, as any nurse can testify who daily looks out of her window upon an unkempt mound of coal, we have not yet run short of fuel, yet we are all trying in many small ways to save the coal that we have. We are having fewer and smaller fires, less frequent and less luxurious baths, and we trudge up flight after flight of stairs looking longingly meanwhile at the lift whose services are denied to us. One light now does where we might have used three before, and a sterilizer which might, a month ago, have been left to boil itself dry, is now turned off after each fomentation has heated through.

Coal is very scarce in the Borough, so scarce that in cases of illness or confinement where warmth is necessary, the Out-Patient Officer or the Charity has to sign certificates granting permission to the patients to buy coal. Even when armed with these certificates they find it difficult to induce the dealers to allow them more than half a hundredweight of coal a week.

This is sufficient for their present needs, chiefly because, owing to the mildness of the warm spring weather which we are enjoying at present, very little if any fire is needed. If the strike had occurred in mid-winter, it would, no doubt, have caused far greater inconvenience and discomfort. As it is, except for an undercurrent of anxiety lest the men should be called up for strike duty, or lest they should lose their work by the spreading of the strike into other unions, there is little distress in the Borough.

In this number of the Gazette we publish at the request of the Superintendent a list of the days and hours of attendances of the members of the Visiting Staff both in the Wards and in Out-Patients. We hope this will be of use to present students who often have a spare half-day which they are at a loss to fill up. It will be of use also to old Guy's men who may wish to send cases up to be seen by some one of the Hospital Specialists or who may desire to visit the Hospital again and to go round with a physician or to watch a surgeon at work. It is unnecessary for us to assure them that they will be truly welcome if they will make such a visit.

Dr. Barber has forwarded to us, and asks us to acknowledge two books which have been presented to the Museum by Dr. Withers Green. They are two catalogues: one of the wax models of diseases of the skin, and the other of comparative anatomy exhibits. They were sent by him in response to a paragraph which appeared some time ago in "Passim," stating that the Museum was without an authenticated catalogue of these models. Dr. Withers Green himself helped Dr. Pye-Smith to compile the Comparative Anatomy Catalogue, and we are very grateful to him for his gift to the Hospital of his own presentation copy.

The Annual Meeting of the Guy's Hospital Ladies' Association will take place, in the Court Room, on Tuesday, May 10th, at 3.30 p.m. Viscount Goschen will be in the chair. Before the meeting there will be an exhibition of some of the work done during the year. It is hoped that as many members as possible will be present at the meeting, which provides a yearly opportunity for the various branches of the Association to come together to discuss and compare the results of the previous year's work and to make plans for the coming year. This year they will also doubtless be interested to visit the new Baby Ward, overlooking the Park on the south side, which will contain the cots endowed and supported by the G.H.L.A.; and also the new Massage buildings which are rapidly approaching completion.

The Baby Ward, by the way, still lacks a name, and we would suggest that here is an admirable opportunity for us to pay homage to Keats by naming this new ward after him.

The Boat Club has been challenged by Bart.'s to a race of coxwainless fours for the Cup which was won by us last year. We are informed that this race will be rowed towards the end of next month, and whereas Bart.'s are reputed to have started training and daily practice a fortnight ago, a Guy's crew has not yet been selected. If we are to retain the Cup, training and practice must begin almost immediately, so we would ask all rowing men who are ready to row for the Hospital to communicate at once either with F. C. Miller or R. S. Chambers, who are the only available members of last year's crew, with a view to beginning training as soon as possible.

Guy's have the use of the London Rowing Club boathouse, and every facility is provided for practice, so that once a crew has been picked and tested there will be no obstacles in the way of thorough training, and in spite of the handicap Bart.'s have obtained we ought to be able to get a fit enough crew to give them a good race.

Pain in the Lower Abdomen in Women.

CLINICAL LECTURE BY HAROLD CHAPPLE.

GENTLEMEN,—It is clearly impossible in one clinical lecture to even touch on all the conditions in women that are associated with pain in the lower abdomen, but I propose to-day to go over with you the stories of some cases that have recently been under my care, because the first four serve as excellent examples of that very large group of female patients that come to you complaining of pain in the lower abdomen, and who to themselves and to the casual observer present no other signs or symptoms, whereas the others have easily recognised physical signs associated with their pain.

CASE I. was a married woman who was recently in No. 3 bed in Queen Ward, and who was admitted because she complained of pain in the left iliac fossa. She had had intermittent attacks of pain that had persisted in spite of the usual medical treatment. The striking feature of the pain was that it was very much worse five to seven days after a menstrual period and lasted in its aggravated form for three or four days, although it occurred in lesser degree at any time during the month. The attacks of pain were associated with varying degrees of abdominal distension. Her menses were regular. A very interesting feature in her history was that she had had one child seven years previously. Her sexual desire was at its highest point five days after a menstrual period. She had had a second child two years ago after a single intercourse which had taken place five days after the period. On examination she was very tender on palpation of the left pelvic brim and a fixed pelvic colon could be made out. Bimanual examination revealed no lump, but her left fornix was tender.

This case interested me very much. As a result of many observations made during abdominal operations, I have found that the rupture of the Graafian follicles in the ovaries occurs without any definite time relationship to the menstrual cycle. In this particular woman the maximum pain was always referred to the left fossa, was at its maximum five days after her menstrual period, and lasted four or five days, and then would get better. Her pelvic colon was anchored in the left iliac fossa. So I left her until five days after her period was over and the pain was at its maximum. Laparotomy was most interesting. The left ovary was caught up in the bands that anchored the pelvic colon at the pelvic brim, and the left ovary was seen to contain a Graafian follicle obviously just about to rupture. She got the pain because her bowel was obstructed, and the ovary being caught up, its time of maximum tenderness and congestion was just when the Graafian follicle was going to burst.

It is additionally interesting because the ovum was thrown out just at this time of the cycle; her sex feeling was at its highest point then, and pregnancy had followed on one intercourse. We have here an explanation of at least some of the cases described as Mittelschmerz and whose pathology has as yet been obscure.

I think it is very important to draw your attention once again to the left iliac fossa. This obstruction to the pelvic colon by the "last kink" has long ago been described by Sir Arbuthnot Lane, but even yet the condition is *not recognised, and is certainly frequently* missed. Yet it is easily and definitely diagnosable. I have operated on a large number of these cases now, and followed up their subsequent history. Those of you who have worked with me in the wards must have seen quite a number. The patient comes to you complaining of pain in the left iliac fossa, which pain is intermittent, and often associated with some degree of intermittent abdominal distension. Palpation reveals an anchored pelvic colon which is definitely obstructed. Laparotomy shows the presence of definite bands on the antero-external side of the pelvic colon at the brim. These can be easily divided, and are found to be quite distinct from the meso-colon. They can be seen in all degrees of development, and produce pain when they obstruct the bowel by binding down the anterior longitudinal bundle to the iliac fossa and so produce a rotation. Discussion has arisen as to what is the origin of these bands. I do not propose to go into that to-day. I wish merely to point out that they are very definite structures which obstruct the bowel, they give rise to a clinical picture that can be easily recognised and can be readily demonstrated at operation. They are much too regular and definite to be of an inflammatory nature. I have not found them in 53 fœtuses that I have dissected. They can be readily divided and their edges sewn over

so as to leave no raw surface. This division frees the bowel and allows the passage of material readily along it, and unless the damage done by the obstruction is too great to be recoverable, the patient gets perfectly well. The left ovary is frequently caught up in their meshes, and so is the left Fallopian tube.

Case II. illustrates this condition. A married woman was admitted to Queen Ward with a history of six weeks' amenorrhœa, and she was then seized with acute pain in the lower abdomen. A diagnosis of extra-uterine pregnancy was made and a laparotomy performed. She was not ill, and it was possible to make a careful observation, and I found her left tube caught up in the "last kink." The tube was acutely flexed and the pregnancy had taken place distal to the obstruction thus produced. I divided the band holding the pelvic colon; the fallopian tube immediately straightened out, andI was able to squeeze the extra-uterine gestation from the lumen of the tube, and it was only necessary to remove the distal three-quarters of an inch of the tube and sew its mucous membrane into the peritoneal surface.

In another patient whose abdomen I opened for pain, one of her causes of distress was her sterility. Laparotomy showed her left tube definitely obstructed by the last kink, and the fimbriated end of the right tube was caught up in an ileal kink. I do not suggest for one moment that it is common to find both tubes obstructed in this way. I have never found it before, but I quite often find the left tube caught up in the last kink.

Case III. is a further illustration of the importance of this pelvic colon obstruction. She was a single woman of 48 who had been menstruating quite regularly. She had a long history of "indigestion," and her abdomen had distended up at intervals so that she noticed her corsets were too tight and she was compelled to take them off to get relief. To her friends she had obviously been going downhill of recent times, but there was nothing more definite than that. When I saw her she had had an acute attack of abdominal pain and distension which had lasted for ten days. Only with the greatest difficulty had anything been passed by the bowel. She had vomited, and on examination her abdomen was greatly distended. She had been seen by an excellent physician, who diagnosed a carcinoma of the pelvic colon. Laparotomy failed to show the presence of a growth, but her pelvic colon was bound down in the usual way in the left iliac fossa, and the left ovary caught up. Division of the band and over-sewing the surfaces allowed the bowel contents to pass along, and a great quantity was evacuated soon after the operation. The pain has completely disappeared.

Again, I do not think you will often see cases in which the obstruction is as marked as it was in this instance, but I use this gross case to show you how definite it may be and to tell you that in lesser degrees it is a very common cause of partial obstruction and pain in women. If you will practice accurate abdominal and pelvic palpation you will have no difficulty in detecting and diagnosing these cases. A large number of the cases that I have seen have been completely missed and treated as functional. A very important part of your training is to learn to put a correct value on the evidence that the patient gives you. You will soon learn to recognise whether the pain is real or not. Then accurately locate where the pain is, and in the cases to which I am drawing your attention the localisation is very definite and simple. I find a large number of the dressers that come to work with me regard the abdomen as a region that cannot be at all accurately palpated. That is not so, and practice will soon teach you to feel the organs in the abdomen quite accurately.

The necessity for this accuracy was well illustrated in

Case IV., a woman of 28, who was admitted to Queen complaining of pain in the lower quadrant of the left abdomen and diagnosed as a salpingitis. She had had a few attacks of frequent micturition, but these had not attracted much attention. The exact site of pain was internal to the pelvic bowel nearer the middle line. The bowel was free and not tender on manipulation. The site of pain was over the left ureter, and its manipulation produced the pain complained of. Microscopic examination of the urine showed a staphylococcus aureus. A catheter specimen drawn from the left ureter gave again a pure culture of staphylococcus aureus and aided by a vaccine treatment, the pain rapidly subsided. These cases are not so rare as one previously imagined and I have lately seen five of them.

The second group of cases that we are considering to-day comprises those in which there is abdominal pain associated with easily recognised physical signs. The common causes of pain sufficient to make the woman come up to Out-Patients for treatment are numerous. You are all quite familiar with cases of salpingitis in which the pain may be very severe. Some of these, on the other hand, present their pain in unusual forms and you will not detect the cause unless your examination is always thorough and complete.

Case V. illustrates this point. A married woman of 42 had been treated for three years for a displaced kidney. She was a professional dancer, and gave a history of having slipped heavily during her dancing, and then of noticing acute pain which she located under the left costal margin. No pelvic examination had been made, and it was supposed that she had displaced her left kidney. She did not improve under treatment, and a vaginal examination showed a large fixed mass behind the uterus. A careful history revealed that she frequently became distended on the left side of her abdomen, and during the attacks of distension she referred her pain to the splenic flexure region. The pain was much relieved by an action of the bowels. When I opened her abdomen there was an inflammatory process affecting both Fallopian tubes, and, as is so commonly the case, the pelvic bowel was partially obstructed by a rotation along its length produced by the appendices epiploacæ becoming adherent to the inflammatory mass. This is a most important fact to realise in the surgical treatment of such cases. If you do not free the bowel and undo its axial rotation you will not relieve the pain caused by its obstruction.

Again, you are all familiar with the pain accompanying an extra-uterine gestation. It is usually severe, but remember the different clinical pictures that are presented according to whether the pregnancy ends by rupturing the tube or becoming a tubal mole. There may be a history of amenorrhœa of some six to eight weeks' duration, but there may be nothing of the kind, and one of the common stories is given by Case VI., a married woman who had had a child three years previously and who since had menstruated regularly. "Her last period," she stated, "was quite regular, but had lasted a fortnight and was accompanied by attacks of severe abdominal pain." Vaginal examination revealed a mass in the postero-lateral fornix, and laparotomy showed that she had a left tubal mole. Remember that mole formation is much commoner than a rupture in cases of extra-uterine pregnancy, and that in the latter cases you will frequently not detect a pelvic lump on vaginal examination if you see the condition early.

The Importance of Diagnosis to the Dental Student.

Paper read before the Guy's Hospital Dental Society by Martin Braun.

Mr. President and Gentlemen,—I must explain at the outset, lest the title of my paper mislead you, that I do not expect to present to you anything very new, rather do I wish to connect up a good many points which arise in our daily hospital practice and to give you some idea of how I regard it all as merely a branch of that not least fascinating of all arts, the art of healing. There have been so many papers read here on definite points of surgery or mechanics, that I fear I shall be going somewhat off the beaten track, and I ask your indulgence if there is nothing startling in my subject matter, and I trust that the worthy critics who may see fit to challenge my statements or ask me questions will deal kindly with me. I feel certain there are some present at this meeting who, like myself, get to feel more and more every day how very little they really do know, and I must confess I consider it a very good thing for it is those who persuade themselves they have nothing more to learn who will most assuredly fail in the long run. We are living in an age of change. So many things which were taken as a matter of course 20 or 30 years ago have been found wanting and relegated to the realm of interesting relics of early fallacies.

In an American Journal recently, I came across the following statement directed to the modern dental surgeon:

"The mistakes of physicians are buried in the ground, the mistakes of lawyers dangle in the air, but the mistakes of dentists stare them in the face, a constant reminder of carelessness, unskilfulness and disregard for the demands of scientific dentistry."

It is very American, perhaps, but I think very true.

The day when only because they had not slept for a week did people go to the dentist to have the offending tooth extracted or to have the one tooth

filled, which their tongue told them contained a cavity, is slowly drawing to a close, and we ought to be glad of this. The dental surgeon of the future will be called upon to fill or extract an odd tooth only in exceptional cases. His business will be the far more important one of keeping the mouths of his patients in good condition whether by scaling, extracting, filling, prosthetic appliances, etc.

He will be called upon to cure, but far more important, to prevent.

Now for practical purposes dentistry is analogous to the sister science of medicine and I think it is an established fact to-day that the most successful medical man (and I use the word successful in its widest sense) is he who can diagnose with skill and certainty.

It seems to me that our system of training as it stands to-day is not very conducive to this end. I fear many circumstances are responsible for this and that it would not be an easy matter to alter it, but the chief trouble appears to be that we romp through our clinical course of two years, a kind of race against time, against those who supply us with patients and against the powers that be, who count up the number of tickets of white and yellow and pink and say: "Thou shalt not be signed up." So many of us, too, are racing against other things and must complete our course in the shortest time possible, much as an extra six months would benefit us.

But important that it be, the work on the phantom head, the fillings we do in the conservation room, the extractions, etc., are, to my mind, only a small part of our training. It is necessary that we should develop so high a technique that we shall be able to turn out a first-class piece of work in any case we may be called upon to undertake. But what is the use of a man who can construct a bridge with four abutments and six dummies, sparkling like a piece of jewellery in a Bond Street window whenever the patient opens his mouth, if he cannot use his powers of observation and diagnosis to decide whether the roots upon which his bridge is to be built are suitable; if he is incapable of telling when teeth affected by pyorrhœa are capable of being made safe and healthy, and when they are like the match held near the powder cask. And so I come to my real contention which is that we should learn our dental surgery principally in the clinical room, where we may see the dental surgeon diagnose his case and decide upon his form of treatment, principally through his experience and powers of observation.

It is easy enough to look at a hopelessly decayed tooth broken down to the gum and septic and to say, "that tooth must be extracted," a man who had never done anything but dental mechanics could probably come to a satisfactory decision in such a case, but it is quite another matter to decide from your clinical observation as to whether say the cause of neuralgia in a particular case lies in the teeth or in a particular tooth—that will distinguish the true dental surgeon, the true diagnostician from the dentist of former days who was, and in many cases is still, regarded by the lay public as a kind of glorified blacksmith who pulls out teeth by force and pushes some kind of stopping into a cavity in a tooth when it hurts. I well remember the feeling of elation produced in me when I found I had correctly diagnosed my first case of a degenerated pulp. I am sure most of you, gentlemen, have felt much the same, but I go so far as to say that the effect of that first correct diagnosis was more far reaching than we quite realised, and was worth to us many amalgams, even several difficult contour golds.

Now it may sound absurd to say that when a patient presents himself for the first time for treatment and there are one or two obviously carious teeth, one should make first a thorough examination of the mouth and ask questions so as to arrive at a correct understanding of the patient's trouble, but I fear that the tendency in the average student is to go like a bull at a gate at the work in hand and set to work trying to save one or other carious tooth. We so often meet with cases which are not correctly treated by doing a few fillings in teeth which are obviously decayed. This in itself may be satisfactory, but one frequently finds a variety of conditions in the mouth of the average hospital patient, and not only for the sake of the patient, but also for that of the student himself is it important to investigate all the signs and symptoms of the condition and then to set out upon a systematic course of treatment which will restore the mouth in question to a satisfactory condition in respect of appearance, function, and general health. One learns so much more by taking a case in hand and treating it step by step from beginning to end until everything that *could* be done has been done, than by doing a few fillings here and there haphazard, and after all our aim is to become dental surgeons in the widest sense, and not mere fillers of teeth.

I think it is no exaggeration to say that seven of every ten patients who present themselves for conservative treatment at this Hospital have some gingivitis present, or at any rate a somewhat septic mouth, and yet it is not the rule that the dresser to whom the patient is allotted will first of all clear up all the sepsis and get the gums into healthy condition, although very often cavities are hidden by tartar or pain which is otherwise unaccountable found due to pockets between teeth

in which food lodges, and yet unless the mouth is cleaned and carefully examined the condition will escape notice, a few fillings of greater or less importance will be inserted and the student will have missed another golden opportunity of increasing his experience and hence his skill in diagnosis, for diagnosis is the correct summing up of all the data derived from the signs and symptoms available, and depends on judgment and experience and how can anyone have judgment and experience in any matter if he has not had to sum up facts again and again, and so trained his mind to deduce one fact from another and gradually work out his conclusions to a satisfactory and probably correct diagnosis?

Let me choose a case which I recently had to treat to illustrate my point. It is not exceptional in any way—rather the kind of thing that crops up every day in the Conservation Room. This was a patient with a very clean mouth and strong and well formed teeth. The lower jaw was perfect except for the right first molar which was very carious and a dead tooth. In this particular case it would have been worth while saving the molar, but on investigation this was found to have its floor perforated and it was decided to extract. The maxilla was rather interesting. On the left side the 2, 3, 4, 5, and 6 were missing, on the right these were all present, but probably owing to tardiness in eruption of the canine a space had occurred between 2 and 4, so that an ingenious dentist had crowned the 4 with a gold cap crown to which was attached a small porcelain facing to form a small bridge, and fill up the space. This dentist could not have diagnosed the case at all for he forgot about the possibility of the canine erupting later and certainly had no radiograph to ascertain the whereabouts of that tooth. Subsequent to the construction of the bridge, the canine erupted and for some reason quite out of the arch and pointing into the palate. The bridge had become loose, and though not intended as such, acted as a removable bridge though a very unhygienic one. Now, looking at only the affected side of the mouth the first point was what to do about the canine. The patient, in age, was far beyond any hope of moving the canine into place, and as its position caused a focus for collection of food and consequent sepsis the obvious treatment was extraction of the canine. As regards the space and the 4 at a first glance one would have said "crown the 4 root again with a metal and porcelain cast or soldered post crown with a tooth attached to fill in the space, but looking at the mouth as a whole it became obvious that on the left side where 2, 3, 4, 5, and 6 were missing a denture was urgently required and it then had to be considered whether as (1) a denture was in any case necessary, (2) a space existed on the right side, and (3) posterior to the space was a not perfect root which would have to be crowned, the wisest treatment would not be to extract both the instanding 3 and the 4, which formed the abutment of the former bridge, and later make a partial denture with two teeth on the right side and 5 on the left and this treatment was consequently adopted on the advice of the dental surgeon for that morning.

This may be somewhat of a simple case, but it well illustrates my contention that it would be well for all of us to pay more attention to exerting our powers of observation and diagnosis, than to the actual number of fillings, etc., which we do, provided we keep in mind the necessity of devoloping first-class technique in the more mechanical part of our work.

There is a tendency in so many when anything unusual occurs without further effort or thought to fly to the radiograph for assistance and inspiration, but surely if we are going to give up diagnosing cases from the signs and symptoms, and instead rely solely on the radiograph we shall be going backwards rather than forwards. I believe it has been said somewhere that the X-ray is an excellent servant but a very bad master, and I think that is no exaggeration. The X-ray is one of our most valuable aids to diagnosis; it so often gives the final certainty to a diagnosis that has been made clinically, it helps us to see where otherwise we can but grope and hope for the best; it gives us greater security in dealing with roots and root-troubles which we only vaguely guess at but cannot see, and therefore cannot be certain of, but it also sometimes gives such a distorted picture of the condition that were we to be guided solely by the radiograph a gross error of judgment would be the result.

Many of us, perhaps I might safely say most of us, will have to carry on our practice after we leave Guy's, whenever that may be, under such conditions that for some years at any rate, we shall have to manage without radiographs. It is a difficult thing to contemplate here where the motto has become "when in doubt have an X-ray." All the more is it necessary therefore that we should learn to judge from the facts at hand and from experience, and use the radiograph only to clinch our diagnosis.

To go solely upon the evidence of the X-ray will lead to many an error. The radiographer will probably maintain that every dark area round an apex of a root indicates a focus of infection and will condemn such root. There are many, however, who maintain that this is not necessarily so and that such an area is only an indication that there has at some time been an infection, but this may have been overcome, for why should there not be resolution after infection round a root-apex just as we know it to occur in other parts of the human

body. Around points such as these the hot controversy rages, especially in the United States, where one faction would condemn all dead teeth, regarding them as foreign bodies, whilst the other faction gaily continues to build bridges and cap crowns in the approved American fashion.

When we come to consider the treatment of children's teeth surely we have a large field for exercising our powers of observation and judgment for maybe upon our correct diagnosis and treatment the whole future health and efficiency of the child may depend. Looking at it from this point of view the three months spent by the students in the Children's Department are three of the most important months of the whole course. Where to save and where to condemn, where to treat and where to potspone treatment, where to insert an appliance and where to treat by systematic extractions, these present problems which are not only interesting, but extremely valuable, and give much food for thought to the keen student. There is something very monotonous in extracting, filling, and scaling day in and day out if one does not look out for wider spheres and deeper interests. The true aim of education should be to teach one to think, and no less in our training should it be necessary to attack problems and ponder over them—only so can we hope to assume a position of importance in the civilised world and be really doing something that matters.

Let us pass on now to one of the most important if not *the* most important aspect of our profession and that is the bearing the condition of the mouth has upon the general health. This in my opinion is the branch of our sphere of activities which requires the greatest experience and knowledge and the deepest thought and care. I cannot get away from the feeling that important as it admittedly is to arrest the inroads of caries, to remedy this by fillings or other treatment to find if possible the true cause of caries, there is a far greater scourge, a far more important and disastrous condition, and that is the disease commonly known as pyorrhœa. In the case of dental caries, at the worst, some teeth are rendered functionless, there is pain and consequent lowering of vitality of the patient, but there is seldom so general an attack of caries as to undermine the health and bring in its train all manner of general disease. But let us look at the other side of the picture and we see a very different state of affairs. One need only spend two or three mornings looking at the mouths of the casualty patients or at those who present themselves at Out-Patients and hear the tale these patients unfold of chronic indigestion, stomach trouble, joint trouble, etc., and in 99 per cent. of cases one glance at the mouth and one is not surprised. The marvel of it is how these people have managed to go on like that as long as they *have*. And the few who have this appalling condition of the mouth and yet have no general symptoms are probably, as Mr. Hopson so aptly puts it, "living on the edge of a volcano." If ever there was a field rich in material for inquiry, observation, diagnosis, surely it is in those cases. And here we must remember too that so many cases cannot be explained satisfactorily.

We find a mouthful of teeth that have been loosened by progressive periodontitis, suppuration all round the gingime margins; we advise the mouth to be cleared and yet the trouble, gastric or joint or whatever it may be does not clear up. It is just this fact that creates such a vast field for investigation for apparently we know only the most elementary facts about this disease. We know that in many cases, treatment of the pyorrhœa, of whatever nature, alleviates the general symptoms; we also know that in some cases not the slightest effect is observed. Every day cases come up from other departments for the report of the dental surgeon as to the possibility of infection from the mouth causing the general symptoms. Sometimes extractions are advised, radiographs taken, gum treatment undertaken, but why do we find pyorrhœa in the mouth of a person who obviously does not neglect his teeth and yet not in so many mouths where there is no attempt at oral hygiene? Why do we find as a rule no caries where there is pyorrhœa and no pyorrhœa where there is extensive caries? Why do we find deep pockets in comparatively clean mouths where there is no suppuration and often scarcely any pockets where there is obvious pyorrhœa. To quote once again one of Mr. Hopson's favourite expressions, "We don't know!"

I think it is not going too far to say that our work in the future is going to become less and less of the nature of patchwork and more comprehensive, and that we shall have to always bear in mind the patient's general health in carrying out our treatment, whether preventive or remedial. Many of our patients will be sent to us by their medical advisers and we shall have to be efficient in our diagnoses and be able to give a clean bill of health or advise extensive extractions or other treatment as the case may be. We shall be working beneath the critical gaze of the sister profession and he who will not undertake seriously and deliberately the restoration to health of such patients committed to his care will go to the wall.

I think that whether we like it or no, it is under this heading of oral sepsis, its causes and effects, that most of our work will lie and we all know how much care and thought so many of these cases require before they are correctly diagnosed and suitable treatment can be undertaken. A few minutes in our clinical room almost any morning will con-

firm this, our radiographer grows increasingly busy and the dental surgeon is as puzzled as ever over some of the cases that present definite and advanced symptoms without any apparent serious cause.

Let me quote one or two examples from the endless number which is available, examples of which I was able to see something recently and which were rather interesting.

The first was a case esnt to us by Dr. Barber of a middle-aged woman suffering from alopecia—falling out of the hair, and therefore coming under the heading of skin diseases. This patient has had her trouble since childhood. The mouth was in quite good condition on the whole, a scaling was necessary and one or two teeth were slightly loose especially the upper incisors, but nothing serious. There was no pus around the teeth on pressing the gums so that here one could not speak of pyorrhœa. The teeth were all radiographed and it was then seen that there was apparently a general absorption of alveolar bone about all the teeth though more pronounced in the case of some than of others, the upper centrals were particularly bad showing quite an eighth of an inch or more of bone absorbed away, similarly the right upper molars as you will see from the radiographs which I am handing round. The lowers were not nearly so bad though there was some absorption even here and a tendency to form pockets. The question now was whether to sacrifice all the teeth, or if not, which to extract and which to leave. In the end all the upper teeth except the canines were condemned and it was decided to attempt treatment of the gums in the usual way in order to save the lowers. The question here is of course in how far this absorption of the alveolus indicated a general septic condition and in how far such septic condition affected the cause of the patient's skin trouble.

One cannot help thinking there must be some connection and it will be interesting to find out what progress the patient will be making say in two or three months' time. Especially in such a case is one inclined to trace a connection between the dental trouble and the general trouble where the skin is affected and we therefore have two strictures, both of epithelial origin to consider. On the other hand one ought not to lose sight of the possibility of the dental condition being effect and not cause. This point has been raised by several teachers especially in regard to gastric troubles and their connection with oral sepsis.

Another case which it might be interesting to consider is one of a young woman who is troubled with continual pain in the head somewhat of a neuralgic character, but yet from the symptoms not a true neuralgia. Here radiographs have not helped much. One lower molar showed absorption about it, a rarefied area of bone and was consequently extracted, otherwise the teeth and gums are being treated and it is hoped that this may clear up the trouble, although it seems to me it must lie deeper than this. It seems in this case that the trouble is to a large extent nervous in origin.

Such are the problems with which we are daily being presented and about which we are asked to decide and surely they need all our experience, skill, common sense and patience in order to diagnose them.

It is most profitable for us to read the dental journals and periodicals, even some of the medical journals. In the GUY'S HOSPITAL GAZETTE, of 22nd January, there is a most interesting case quoted of marked anæmia and degeneration of the spinal cord associated with advanced pyorrhœa alveolaris. It is instructive and helpful. But do we all do our duty in this respect and widen our knowledge and experience by every means at our disposal?

The Odontological Section of the Royal Society of Medicine holds regular meetings at which visitors are welcome. There the most expert opinions on all matters of interest to the profession may be heard, but do we take full advantage of these opportunities, do we keep in mind the real aim of all our training?

It is surely, at the present time, fatal for anyone to enter upon his dental course with a view to its giving him so much of an income at some future date, and to work with his eyes glued on that object, to pursue the narrow path which in this case must prevent his becoming anything but a mere machine.

The need of the future seems to be, as regards dentistry, for men of clinical experience, men who will devote themselves to solving the problems that beset us on all sides, and will regard the cut and dried methods of treatment of the past as useful aids, but not as the alpha and omega of their profession; who will allow not even the smallest sign to escape their observation if it is likely to help in the diagnosis of the case in hand.

Gentlemen, I don't know whether I have put my ideas very lucidly to you and whether I have in your opinion in any way shown why it is so vital for us all to pay far more attention than most of us do to a wide and thorough clinical observation of everything we are called upon to treat and to drink in with eyes and ears the opinions of those who bring their years of experience to bear on our work and teach us to diagnose correctly.

Perhaps some of my words may sound idealistic, but I venture to state that without a certain amount of idealism, we should be sorry beings indeed. I cannot admit that our profession is materialistic. Only recently I was told of a Guy's

man who has been in practice a few years and has now arrived at the stage where he is very busy all day long. He remarked that his greatest trouble now was to prevent himself from doing shoddy work.

It is a thing to remember and ponder over and I think we might all of us well pray daily: "Not to be tempted to do shoddy work."

There is a well-known saying: "There is nothing new under the sun," and perhaps we really know nothing that is new, but if by regarding well-known facts in a new light and with a higher aim in view, we can place dentistry on a higher plane and better alleviate human suffering, we shall at least have accomplished something here below.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

Admission of Dental Pupils to Guy's.

DEAR SIR,—It is with extreme regret and some annoyance that I feel in duty bound to write you on the issue by the Medical School of the printed letter *re* the admission of pupils trained privately in Dental Mechanics.

Some years ago the private practitioner was extremely hard hit in the way of securing pupils by the introduction in the hospitals of a mechanical course. Now it seems that insult is to be added to injury by the blunt fact that pupils privately trained in mechanics will be refused until some date unknown. At least, as far as the Guy's Medical School Authorities are concerned, they could extend the privilege of entry to sons of Old Guy's men, who will find it hard not to be able to send their own sons and so maintain old traditions.—Yours truly,

H. R. CODRINGTON BUTLER.

Holly Lodge,
Tiverton, Devon.
April 18th, 1921.

A Case of Retroperitoneal Hæmorrhage.

DEAR MR. EDITOR,—In the GAZETTE of November, 1919, I wrote an article on "Two Cases of Retroperitoneal Hæmorrhage."

It might be of interest to know that the first case described—that of the woman admitted into Charity—went to a hospital outside London in November, 1920, a year after her operation. She was again complaining of a swelling in her right loin. She had had no hæmaturia or frequency although the swelling was obviously renal. Mr. Turner, as surgeon to the hospital decided to operate. An abdominal incision was made and a large kidney on the right side was found. It was removed with difficulty and a considerable amount of bleeding took place, owing to the shortness of the pedicle and the slipping of a ligature. No trace of the previous retroperitoneal hæmorrhage was to be found. The excised kidney was of a bluish black colour, especially at the lower pole where the chief enlargement was to be noticed. On section the kidney had its lower pole completely replaced by a black gelatinous looking mass. Microscopical examination by Dr. Nicholson proved the mass to be a case of melanotic sarcoma.

The patient died shortly after the operation and unfortunately no post mortem examination was made.

The questions now raised are, Was the eye which was removed for some "tubercular trouble" really a case of growth?

Was the retroperitoneal hæmorrhage due to a hæmorrhage into the growth and later an extravasation into the retroperitoneal tissues?

If the eye was growth presumably the kidney was secondary to the eye.—I am, Sir, yours, etc.,

T. G. D. BONAR,

Guy's Hospital,
London, S.E. 1.
April 12th, 1921.

The Business Side of Medical Practice.

SIR,—In his letter published in your issue April 16th your correspondent "Ex-Resident," brings forward several very important points.

The fact that the business side of our profession is overlooked has a most harmful effect on the profession. No adequate attempt has ever been made to obtain representation in Parliament with the result that while the legal profession looks after itself well, our profession has to get on as well as it can and consequently is exploited both by the State and Public. The B.M.A., which is supposed officially to represent the views of the profession, actually does not do so, and seemingly on important matters, after making a certain amount of noise, invariably gives way to the Government. The present position of practice is unsatisfactory owing to practitioners having to cut prices in order to earn a living, and we have no organisation or combination to stop price cutting.

Even with the existing shortage of doctors the standard of fees is very low, and it is already recognised that when the large number of students who joined the schools after the war come into practice the situation will become very grave. To quote an instance to show how the profession is exploited, a District Medical Officer is still ex-

pected to visit a pauper lunatic for 2s. 6d., regardless of distance.

By the time a medical student has paid for his education, his practice, and his car it is very doubtful if he will receive as adequate a return on his capital as if he had gone into business, and he will certainly have a harder life and more trying time. Shortly all the professions will be overcrowded and the tendency of all classes is to go into trade or business. The real need of our profession is combination and co-operation. We then could put it on a business-like and profitable basis.—I am, yours faithfully,

G. W. C. HOLLIST.

Otley, Ipswich.
April 25th, 1921.

Sir,—Your correspondent who signs himself "Ex-Resident" brings forward many points of vital interest to that vast majority of Guy's men who will become general practitioners.

Looking back one remembers no teaching whatever on the conduct of a general practice, the question of fees, the number of visits that should be made, the question of purchase—in fact a host of points that are of the greatest importance to every beginner.

Except as a house officer one never came in contact with the G.P. and then only occasionally. Would it not be possible to have two or three lectures given each year by general practitioners on these points? Attendance at these would of course be voluntary, but I venture to think that no janitor's services to note absentees would be required. I suppose most of us who are medical practitioners would, if only those dear old students days could return, pay but scant attention to the hæmorrhagic pancreatitis and the splenomegalic cirrhosis as compared with the interest we should devote to say early phthisis and the dyspepsias, etc.—I am, Sir, yours, etc.,

P. SEYMOUR PRICE.

The War Memorial.

Dear Sir,—I submit the following for your consideration:—

"To the glorious memory of those who fell in the Great War, and to the honour of those who came through."—Yours faithfully,

Oakhurst, E. M. M.
Crofton, Orpington.
April 17th, 1921.
London, S.W.1.

Dear Sir,—May I suggest the following as a suitable inscription for the Guy's War Memorial:—

"Remember with thanksgiving the true and faithful men who, in the Great War, went forth from this place for God and the Right. The names of those who returned not again are hereon inscribed, to be honoured for evermore."

I came upon it by chance in a little volume entitled "Enchanter's Nightshade," by J. B. Morton on Saturday last, and it seemed to me simple, beautiful and singularly appropriate.—Yours faithfully,

ERNEST D. BASCOMBE.

Melford Lodge, Bourne Avenue,
The Square, Bournemouth.
April 19th, 1921.

The Results of Reconstruction.

Dear Sir,—Perhaps one who had had experience at Guy's both before and since the war may be permitted to reply shortly to your correspondent. "Progress not Change." The Reconstruction Report of the School laid it down that Guy's had three functions to fulfil:—(1) The treatment of the sick poor, (2) the education of medical practitioners, (3) the advancement of medical knowledge. Now, although there are institutions where the first and third of these functions can be admirably carried out without the second, everyone is agreed that no satisfactory medical education is possible without attention being paid to the other two. Consequently I am rather surprised at your correspondent omitting all mention of them in his remarks, and concerning himself chiefly with certain alterations in the time-table.

I will deal with his points in order. The system of assistant surgeons' dressers clerking at Out-Patients had died out a short time before the war, when beds were allotted to the assistant physicians, and they had clerks of their own. The present system has the great advantage to the assistant physician, and, I think, to the students, that the former is teaching the same men both in the wards and at O.P.s. so that some continuity in teaching is possible. The morning's out-patients is also an advantage. The "keen clerk" of the pre-war days as sketched by your correspondent, was nearly, if not quite, a mythical person. At present the clerks can be given new cases to examine as soon as they arrive in the morning, and the cases can be examined subsequently by the physicians, who can see some of the old cases first. During the last three months I have comparatively rarely examined a new case which had not been written up and much more thoroughly examined by the clerk than in the old days.

The School Authorities were fully aware of the greater importance of ward work than attendances

at lectures; surely they showed this when they abolished compulsory systematic lectures in medicine and surgery. I must differ from your correspondent, since I maintain that there is great educational value in lecture-demonstrations.

The question of dressers not living up in the College hardly concerns reconstruction; it is partly due to the difficulty of getting rooms in the College and partly to the economic consequences of the war.

I cannot speak with regard to the present dressing at operations, but I can say that when I was A.H.S. before the war, it was the custom for the house officer to wash up and lend a hand in difficult cases.

The official hour for P.M.s. has always been 2 p.m., largely I suppose, to suit the convenience of the physicians and surgeons who might wish to see the autopsies on their cases. If there is any large body of opinion in favour of altering it to 1.30, I imagine their wishes would be acceded to, if representations were made to the proper authority.

My impression is that some such alteration is already in contemplation.—Yours etc.,

E. P. POULTON.

April 18th, 1921.

In reply to Dr. Poulton's letter, which has been submitted to me before publication by the kindness of the Editor of the GAZETTE, I should like to bring forward certain points. If he reads my original letter he will find that I admit "that there has been an increase in the facilities for study among senior students and qualified men." This I take it more or less covers his third function to be fulfilled by the Hospital, namely, "the advancement of medical knowledge." As to his first point "the treatment of the Sick Poor," I cannot see any point in which the Reconstruction scheme has affected them. It is therefore with his second point, the education of the student that my original letter chiefly dealt.

I am glad to see from his letter that my point about the hour at which P.M.'s are performed is already under consideration. Unless I am mistaken the suggestion for the earlier hour was made in "Passim" many months ago.

As regards the question of morning Out-Patients, I still fail to be impressed by Dr. Poulton's arguments, and I am not inclined to agree that "the keen clerk" of pre-war days is a pure myth. I fail to see how old patients can be seen first at Out-Patients, as by the Hospital regulations they are not due to arrive at Out-Patients until an hour or more after the new cases, quite apart from any difficulty as to space, couches, etc.

No one can agree more heartily than myself with the abolition of the "compulsory" systematic lectures in medecine, etc., but I was under the impression that they were compulsory only from the point of view of the requirements of examining bodies, and I did not realise that the Reconstruction Committee had to be congratulated on their abolition.

I should like, if I am permitted, to raise one further point. At present medical ward clerks are constantly absent from their physician's rounds in order to "run the Front." I realise that this arrangement was made to meet the shortage of dressers, but the size of surgical firms has now risen to well up to the average pre-war standard of three dressers a firm and there is still no sign of medical ward clerks being relieved of the Front in the afternoon. The system of first 3 month ward clerks running the Front needs no comment. Why not the Porters?

As regards other points such as assistant surgeons' dressers at medical Out-Patients, and the position of house surgeons at operations, I fear I must continue to disagree both on points of opinion and of fact.

"PROGRESS NOT CHANGE."

Pass List.

University of London.

SECOND EXAMINATION FOR MEDICAL DEGREES.

PART II. MARCH, 1921.

T. S. Blacklidge.
W. G. Booth.
C. G. Bowen.
L. W. Cann.
D. A. L. Crawshaw.
G. F. Gibberd.
E. J. Greenwood.
D. J. T. Jeans.
Emrys Jones.
J. J. Lewinstein.
N. L. Lloyd.
G. O. Mitchell.
Maurice Mitman.
Paul McG. Moffatt.
E. C. Neser.
A. T. W. Powell.
W. G. Sears.
H. C. C. Taylor.
J. L. L. Walker.

Change of Address.

H. Colwell Rook, M.B., B.S., 51, Upper Tything, Worcester.

C. P. Symonds, 74, Wimpole Street, W. 1. Tel. Langham 1076.

R. Affleck Greeves, 23, Wimpole Street, W. 1. Tel. Langham 2670.

R. Howard, Devon House, Buckhurst Hill, Essex.

C. C. Holman, M.B., F.R.C.S., 21, Billing Road, Northampton. Tel. 337.

Papers by Guy's Men.

W. M. Mollison, M.Ch., F.R.C.S. Hoarseness.—*Clinical Journal*, vol. l., p. 241.

Guy's Hospital.

Time Table for Out-Patient and In-Patient Attendances of Medical and Surgical Units and of Out-Patient Attendances in the Special Departments.

Medical Wards and Out-Patients.

Monday (a.m.)—
Dr. Hurst (Wards).
Dr. Barber (Wards, Skins, 10).
Mr. Mollison (Wards and Ops., 10).
Dr. Mutch (Medical O.P.'s).
Mr. Hughes (Surgical O.P.'s).
Dr. Cameron (Children O.P.'s).

Tuesday (a.m.)—
Mr. Thompson (Wards and Ops.).
Dr. Cameron (Children's Ward (T) 11).
Dr. Hunt (Medical O.P.'s).
Mr. Bromley (Surgical O.P.'s).
Mr. Thompson (G.U. O.P.'s).

Wednesday (a.m.)—
Dr. Hurst (Wards).
Dr. Cameron (Children O.P.'s).
Dr. Marshall (Medical O.P.'s).
Mr. Slesinger (Surgical O.P.'s).
Drs. Symonds and Craig (Neur.-Psych. O.P.'s).

Thursday (a.m.)—
Dr. Hurst (Wards).
Mr. Mollison (Wards and Ops., 10).
Dr. Ryle (Medical O.P.'s).
Mr. Turner (Surgical O.P.'s).
Dr. Barber (Sk. O.P.'s).

Friday (a.m.)—
Mr. Thompson (Wards and Ops.).
Mr. B. Smith (Wards and Ops., 10).
Dr. Barber (Wards, Skins, 10).
Dr. Poulton (Medical O.P.'s).
Mr. Davies-Colley (Surgical O.P.'s).
Dr. Cameron (Children O.P.'s).
Mr. Thompson (G.U. O.P.'s).

Saturday (a.m.)—
Dr. Marshall (Medical O.P.'s).
Mr. Slesinger (Surgical O.P.'s).
Dr. Symonds (Neur. O.P.'s).

Monday (p.m.)—
Dr. Beddard (Wards).
Dr. French (Wards).
Mr. Eason (Wards and Ops. 2).
Mr. B. Smith (Wards and Ops. 2).
Mr. Chapple (Gy. O.P.'s).
Mr. Ormond (Eye O.P.'s).
Mr. Layton (Thr. O.P.'s).
Mr. Trethowan (Orth. O.P.'s).

Tuesday (p.m.)—
Dr. Fawcett (Wards).
Dr. Beddard (Wards).
Mr. Ormond (Wards and Ops. 2).
Mr. Chapple (Wards (T) and Ops. 2.15).
Mr. Layton (Ops. 1.30).
Dr. Barber (Sk. O.P.'s).
Mr. Eason (Eye O.P.'s).
Mr. Mollison (Thr. O.P.'s).
Dr. Marshall (Tub. O.P.'s).
*Mr. Bromley (Fractures O.P.'s).
*Dr. Eyre (Vaccine O.P.'s).

Wednesday (p.m.)—
Mr. Trethowan (Orth. O.P.'s).
Mrs. Vaughan (V. O.P.'s).

Thursday (p.m.)—
Dr. Fawcett (Wards).
Dr. French (Wards).
Mr. Eason (Wards and Ops. 2).
Dr. Cameron (Children's Ward 2).
Mr. B. Smith (Gy. O.P.'s).
Mr. Ormond (Eye O.P.'s).
Mr. Layton (Thr. O.P.'s).

Friday (p.m.)—
Dr. French (Wards).
Dr. Fawcett (Wards).
Mr. Ormond (Wards and Ops. 2).
Mr. Eason (Eye O.P.'s).
Mr. Mollison (Thr. O.P.'s).
*Mr. Trethowan (Orth. O.P.'s).
*Dr. Eyre (Vaccine O.P.'s).
Dr. Marshall (Tub. O.P.'s).

Surgical Wards and Theatres.

Monday (p.m.)—
(T) Mr. Steward—
Mr. Fagge, Mr. Davies-Colley.
Mr. Rowlands, Mr. Bromley.

Tuesday (p.m.)—
(T) Mr. Rowlands—
Sir Alfred Fripp, Mr. Turner.
Mr. Steward, Mr. Hughes.

Thursday (p.m.)—
(T) Sir Alfred Fripp—
Mr. Fagge, Mr. Davies-Colley.
Mr. Rowlands, Mr. Bromley.

Friday (p.m.)—
(T) Mr. Fagge—
Sir Alfred Fripp, Mr. Turner.
Mr. Steward, Mr. Hughes.

* = For reference only.
(T) = Special Teaching Rounds.

Evening Out-Patients.

Mondays.—Male V.D.. Female V.D.

Wednesdays.—Tuberculosis. Male V.D. Female V.D.

Thursdays.—Male V.D. Female V.D.

Two Hospital Vignettes.

OP. THEATRES 3 and 4.

A trolley comes trundling out from the operating theatre carrying a man half comatose. Three women of the poorer class stand by the door of the ward and watch the students guide the trolley through the door, it closes on them.

The door opens and one student walks by. One of the women is in tears and another is trying to comfort her. The third woman is watching for the other student through the open door; she sees him coming down the ward and anxiously turns to the others:—"'Ere, arsk 'im." She stands in the student's path, he realises she wishes to speak to him, for hospital life is a series of pitiful appeals, as every student soon learns. "Docter, she wants ter know what time she can see 'im ternight, it's 'er boy." The mother is weeping bitterly. "'E's jist gorn in." "I'm afraid I can't tell you, but sister

will be out in a moment, she will tell you." The woman is silent. The student passes on, then, he turns round as though he realised he had denied a small comfort to a bereaved creature. "Don't worry mother, he'll be alright." The grief stricken mother fights her tears, and the student passes through the doors labelled Op. theatres 3 and 4.

THE URCHIN.

The ward clerk lifted her off the bed, she didn't cry or kick, she just whimpered like some young animal taken from its mother. She was afraid, terribly afraid. What were these men in great white overalls and white masks? they terrified her. Where was she being taken? and why?

Clouds of steam came out the operating theatre door, perhaps they would burn her? Then they laid her on a white table and an old man with a nice face and wearing an apron held her little clenched fist. What were all these men going to do? Ghosts, yes, that was what they were—ghosts. Then someone by her head put something over her face, she fought, she screamed, she kicked. What was this terrible stuff she had to breathe? She was choking, another struggle and then no more.

Poor little urchin, her arms outstretched, her fists still clenched, she sleeps quite calmly. The old man with the nice face bends over her. Suddenly her hand relaxes, it opens and on to the theatre floor fall three coppers.

W. G. B.

Reviews.

A Text Book of Pharmacology and Medical Treatment for Nurses. By J. M. Fortescue-Brickdale, (Oxford Medical Publications.) Price 25s. net.

This book should prove useful as a book of reference for nurses. The author has collected and condensed an enormous amount of information embracing the whole field of pharmacology and medicine.

The book is well written and the subject matter accurate, but it appears to us that any attempt at explaining the deeper problems of pharmacology and medicine to those who have little or no knowledge of physiology and chemistry is largely futile. Pharmacy and dispensing—which are largely a matter of drachms, ounces and common sense—a nurse can reasonably be expected to master, but no one who has not a sound grounding in physiology and chemistry can be expected to appreciate the action of atropine on the heart or to comprehend a discourse on ionisation.

This book, moreover, abounds in a superlative wealth of detail. For instance, we imagine that it would tax the most encyclopædic house-physician to furnish much information about nirvarnine, mesotan or citrophen.

Of all the subjects with which the first year medical student is afflicted, botany is perhaps by common consent the most useless. In this book are to be found innumerable pictures of medical plants. Highly desirable as it is that a nurse should be familiar with the dose of strychnine as met with in a hypodermic tube, it is highly improbable that she will ever be called upon to recognise Strychnos Nux-vomica—the poison nut which makes such a pretty picture against the title-page.

The description of the various medical diseases with the nursing treatment of each is full and concise, and this part of the book is likely to prove of much practical use.

Appointments.

A. L. Punch, M.B., M.R.C.P., Physician (in charge of Out-Patients), Great Northern Central Hospital, Holloway.

R. Affleck Greeves, Surgeon to The Royal London Ophthalmic Hospital, Moorfields.

We regret that the final appointments of dressers to the Genito-Urinary Department (Mr. Thompson) had not been made in time for the last issue of the GAZETTE. They are as follows:—Messrs. F. Bekker, H. W. Taylor, G. B. Kirkland.

Guy's '89 Club.

The following members have notified their intention to attend the 26th Annual Dinner of the Club at Hotel Cecil, on 11th May:—A. P. Beddard, C. E. Carpmael, H. W. Collier, C. H. Fagge, R. H. Fagge, G. L. Eastes, C. D. Edwards, C. A. Ensor, W. S. Handley, W. Henson, A. C. Hovenden, J. A. Howard, M. A. Key, B. G. Reynolds, W. E. Robinson, A. Scott-Turner, E. T. Shorland, F. J. Steward, H. M. Stewart, E. R. Thomas and W. Tyson.

The Secretary will be glad to hear from any other members, who are able to come, not later than Monday, 9th May, reply cards to be sent to H. J. Spon, 61 Harley Street, W. 1.

Athletic Sports.

It has not yet been possible to fix the date for the Hospital Athletic Sports, as the date of the Inter-Hospital Sports has not been settled, but they will be held at Honor Oak Park either on the fourth or the fifteenth of June. The actual date will be announced in the next GAZETTE. The University of London Sports, on the other hand, are definitely fixed for May 25th at Queen's Club, and there are only three and a half weeks between now and then, in which to get fit. Last year we tied with King's College for the "Rosebery" Cup, this year we must make sure of winning it. No team is chosen, the entries being individual, and in order to win the Cup we must have a large number of men, fit and trained, in for each event. The fact that Steyn is going to win the 100 yards should not prevent every other sprinter in the Hospital from trying to get second or third places, which each contribute points to our total. Then again, places in the field events, particularly in the "hammer" and "weight," are gifts for anyone who will spend an hour or two in learning how to throw these things. Knack plays a greater part than strength in these competitions and if anyone, who feels like getting his photo in the "spit" as one of this year's winning team of the "Rosebery" Cup, will give his name to either

R. S. Chambers or L. G. Housden, they will be tickled to death to have him trained, and no expense will be incurred. Lastly we must win the tug-of-war again. Last year we won with a team picked up on the ground, but the practice is a little risky, and with the revival of inter-firm tugs in the Park, we ought to be able to get an eight, sufficiently trained to make sure of this event.

The Annual General Meeting of the Athletic Club will be held early in May.

Football.

Junior Rugby, 1920–21.

"A" XV.

The "A" XV. were extremely unfortunate in having eight fixtures scratched by their opponents. Another was abandoned owing to a greater desire to witness the Gloucester match than make the journey to Horsham and play Christ's Hospital. Whilst two more were cancelled for Kent Cup matches.

It is perhaps due to all these disappointments and lack of practice, that the team played indifferent football in the opening stages of the season.

However, several very keen games were played, notable of which were those with Southend, Old Blues and the R.N.C., Greenwich. By February everyone had become keen and during the Inter-Hospital Cup matches some really good play was witnessed. A report of these appeared in the last issue.

In the Kent Cup Westcombe Park were defeated in the Second Round, whilst in the Semi-Final the Old Dunstonians although leading by 8 points to 3 points nine minutes before time were finally defeated by 17 points to 8 points. This was achieved by our forwards overcoming the Dunstonian pack, which had largely controlled the game up to this point, and giving Sprong frequent opportunities for opening up the game; four of the resulting movements produced tries, one of which Nurick converted from a wide angle.

It is to be regretted that the strike prevented the R.E.'s Chatham playing off the Final, as judging by the excellent form shown by the team in defeating Cardiff and the keenness of everyone concerned, this Cup might easily have been added to the Hospital collection.

"B" XV.

The "B" XV., captained by J. A. Currie, have had a very successful season, many of their games being won by a very small margin after very hard fights. Typical of these was the game at Woolwich when the R.M.A. "A" XV. were defeated by 19 points to 15 points, after playing extra time to obtain a decision. Special notice should be taken of the fact that on two occasions this team, under the title of Guy's "A," played the "A" XV.'s fixtures, losing to the R.A.F., Uxbridge, by 14 points to 6 points, after leading at half-time by 6 points to nil; and on the other occasion they drew with the O.M.T.'s "A" XV.

Great disappointment was caused by the non-inclusion of this team in the draw for the Junior Kent Cup, owing to some error or misunderstanding. It would be a surprise if either of the finalists in this Cup could defeat the "B" XV.

"NOMADS."

The "Nomads," captained by Longhurst, have met with varying fortune and always had enjoyable games, if not first-class changing accommodation, which is after all but a secondary consideration.

Several leading London Schools were visited throughout the season, and it is to be regretted that on one of these visits someone gave vent to his feelings and set the lads a bad example by actually swearing, when at the bottom of a loose scrum. This speaks well for the restraint made in all the other trying circumstances which must have occurred during the other school matches.

Record for Season 1920—21:—

"A" XV.—Played (not including Cup matches) 18; won 12, lost 6, drawn nil; points for 328, points against 110.

"B" XV.—Played 25; won 19, lost 4, drawn 2; points for 402, points against 126.

Nomads.—Played 20; won 10, lost 10, drawn nil; points for 213, points against 180.

In spite of over 200 names, of men wishing to play, being appended to the lists at the commencement of the season it was found difficult to raise teams for many games, especially towards the end of the season. It was necessary to scratch matches on two or three regrettable occasions, and at other times this extremity was only avoided by the willingness of one or two senior men and others, who had not previously played rugger, to turn out and complete the sides. Some among the latter showed great promise and it is to be hoped that they will take up the game seriously next season.

At the next General Meeting one would like to hear suggestions, which will obviate the difficulty of having to complete the teams at noon on Saturdays, a matter of great inconvenience and anxiety to those attempting to run the various teams.

Births.

MARSHALL.—On the 18th April, at 20, St. Mary Abbotts Terrace, Kensington, W. 14, to Belle, the wife of Geoffrey Marshall, M.D., M.R.C.P., a son.

MARSHALL.—On April 19th, at 1, Dartmouth Place, Blackheath Hill, to Kit, wife of R. P. Marshall, M.R.C.S., L.R.C.P., a daughter.

DEPREE.—On April 8th, at 1, Higher Summerlands, Exeter, to Hubert and Lilian Depree, a daughter.

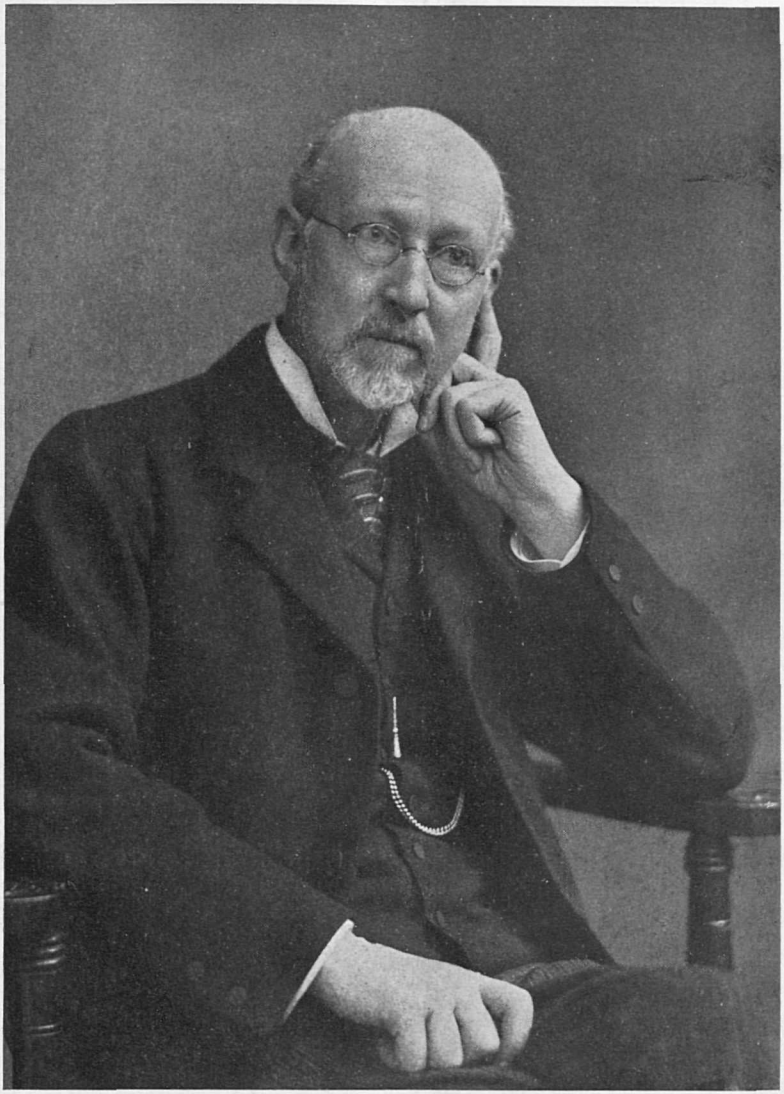
Marriage.

THORNTON—FAWKES.—On April 20th, at St. Alban's Church, Leicester, The Rev. Cecil Grant Thornton to Winifred Dorothy Fawkes.

Death.

BURTON-BROWN.—On the 21st April, at 112, Tonbridge Road, Maidstone, Gerald Burton Burton-Brown, M.D., retired R.N., youngest son of the late T. E. Burton-Brown, M.D., C.I.E.

Ed.—A. T. R.



R. J. PYE-SMITH, Ch.M. (Sheff.), F.R.C.S. (Eng.)

GUY'S HOSPITAL GAZETTE.

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Passim.

THE War Memorial Committee met on Friday, 29th April, to consider the protest which had been raised against their previous decision for the inscription for the Memorial. As before, the alternative suggestions considered were ones which had appeared previously in the GAZETTE, and, as before, it was one of these that was chosen. For the Committee wish emphatically to dispel the idea which is current, that they invented the inscription which has proved so abhorrent. It was merely one of the many phrases which had been brought forward by readers of the GAZETTE and which had appeared in the correspondence columns without bringing one letter of protest. The Committee has discarded its original choice, and has decided to adopt the quotation which has been advocated in "Passim"—"Their name liveth for evermore." This has been suggested now for some weeks, and has so far raised no serious condemnation. We hope that now that it has been finally chosen by the Committee it will not be subjected to such a flood-tide of rightfully wrathful criticism as that beneath which its predecessor sank.

The protest has had this other beneficial result—it has brought more money into the War Memorial coffers. For several of those men who protested had been, because of their absence from the Hospital or their overdrawn accounts, unable to subscribe when subscriptions had last been solicited. Now, wishing to give weight to their protest, they have opened wide their purses. Still however, the Hon. Secretary tells us his subscription lists are not closed and he will be glad still to receive any money that may be sent him. Money is still needed to pay for the War Memorial number of the "Reports." This volume is to contain portraits of each of the fallen, and also other illustrations—showing the completed Memorial and the opening ceremony, which will take place in July in the presence of the Prince of Wales. The present cost of printing, and especially the cost of producing blocks for illustrations, will make this volume an expensive one; so we would ask all those that would subscribe and have not yet done so to send their subscriptions soon to Dr. Pembrey. Dr. Pembrey would also be glad to obtain further particulars of the lives of the men that have been killed, as he finds it difficult to compile complete obituaries for many of them. It is also not generally realised that the names of all men, who were students at Guy's at any time before the Armistice, and who served in the Forces, whether they were

qualified or not, and whether their service was done before or after they came to the Hospital, are to be included in this volume of the "Reports." All men who, through misunderstanding, have not sent in their names should do so as soon as possible.

The second number of the new series of the "Guy's Hospital Reports" has now appeared, and maintains the high standard which Dr. Hurst, as editor, set himself by the excellence of his first number. Containing, as they do, accounts of all the new work and all the new thought of the Hospital, the "Reports" have become an invaluable source of progressive knowledge to all medical men. They are of especial value to all Guy's men, past and present, qualified and unqualified, for, being entirely the work of Guy's men, they are written in accordance with the line of teaching of the Hospital. We would especially urge those men who are in the earlier, the pre-clinical years of study to become subscribers to the "Reports." They will find much in them on physiology and kindred subjects that will already interest them, and they will soon be able to appreciate the clinical articles which make the publication so valuable. This work will not find its way into the text-books for some years yet, and every man who would keep abreast with the times must read some such journal and have it by him so that he may refer to it when it is necessary.

The "Guy's Hospital Reports" are unique; there is as yet no quarterly publication in Great Britain like them, though other hospitals would do well to take the lead set them by Guy's and to produce similar reports which would be, in their place, we do not doubt, equally welcome and equally valuable.

A detailed review of the second number of the Reports will appear shortly in the Gazette.

This number of the Gazette is a special Publishers' Number, and as we gaze through the long lists of books which are advertised in the Gazette this week we are impressed by the numbers of new books and new editions which have appeared in the new year. Truly, "of the making of books there is no end." Equally true, however, is the second part of this quotation ". . . much study is a weariness of the flesh." We cannot hope to read all these books; we despair of reading even those which we wish to read. For books take time to read, time which may have to be spent at less pleasant, but more necessary, tasks; and books nowadays are often expensive luxuries. Still, we welcome the publishers' announcements and the reviewers' accounts of all these new books, for there are always several books among them which we feel we must obtain by some means or other; we must beg, borrow, steal, or review.

The Baby Ward has not yet been officially christened. Two factions wage wordy-war against each other. One, led by a physician whose every thought is for the Baby Ward, speaks and writes of it on all occasions as Keats Ward. The other, with a no less distinguished champion, insists that it is traditional for the Hospital wards to be named after Biblical characters, and wishes to name the ward after the Infant Samuel.

May we point out that this tradition, if it ever existed, was broken long ago. (The name of Astley Cooper is not to be found in any one of the translations of the Bible.) In place of the old habit there sprang up the far more pleasing custom of naming wards after great Guy's men. It is surely better to com-

memorate and do honour to some of the greatest sons of Guy's, rather than to long-forgotten Old Testament personages with unpronounceable names and doubtful characters. Why then revive an obsolete custom which would prevent us from commemorating our only great poet in this his centenary year?

Sir William Hale-White has kindly allowed us to publish as illustrations to his lecture on Bright, which appears in this Gazette, two photographs of the old Clinical Wards, John and Miriam, which were recently destroyed in order to make room for the new buildings in the Park. It was in these two old wards that Bright made most of the investigations which led to his epoch-making papers on renal disease. These old clinical wards were the oldest part of the Hospital that we had left, and we were sorry that the progress of the newer healing arts demanded their replacement by a many-storied building equipped with all the elaborate instruments with which the masseur now practices his mystery.

The photographs were sent to Sir William in response to an appeal made in Passim some months ago for a good picture of the old wards. We have to thank Miss Smith and Miss Strick for enabling us to publish them.

At present the builders who are at work upon the new Massage Building are burrowing up the Park to connect the new building by subway with the Nurses' Home and the rest of the Hospital. Although this new subway runs within a few yards of the Medical School no attempt seems yet to have been made to connect up the School with the Hospital. It has always been a grievance with the men in the School that although one could go underground almost anywhere else about the Hospital—from the Surgery to Patience, from Victoria to Nurses' Home—yet to go from the College or the Biology Laboratory to the Medical School one had to run frantically across the Park through rain, hail, or snow, and then dive helter-skelter down the steepest and most inconvenient flight of steps imaginable before one reached shelter in the Cloak Room. It seems that there is now an excellent opportunity to remedy this. If the subway be driven a few more yards it will reach the School Cloak Room and will link up the Medical School with the Hospital and College.

The inter-firm tug-of-war tradition is being well kept up. Two firms—Dr. Fawcett's and Mr. Steward's—issued challenges to Queen (the gynæcological unit) who were the holders. In the tug which was pulled to decide which of the challengers should have the honour of disputing the cup with Queen, Dr. Fawcett's firm was easily beaten for they lost two pulls running to Mr. Steward's firm. The challenge tug took place on Tuesday last, and Mr. Steward's firm had an even easier victory. They won two consecutive tugs neither of which seemed to have given them any difficulty. The Steward firm team is a heavy and well-matched one, and may with confidence, now that they are holders of the cup, bid defiance to all-comers. We would suggest to the Secretaries of the Athletic Club that they would form an excellent nucleus round which a Hospital team could be built for the University and Inter-Hospital Sports. The University Sports take place on May 25th. We wish all our athletes the best success.

We offer our most sincere congratulations to Mr. W. Kelsey Fry on his winning the Cartwright Prize (a gold medal and an honorarium of £85) presented by the Royal College of Surgeons.

WE have been asked by an old Guy's man, Dr. G. R. Hind, to request any Guy's man that has votes for Foundation Scholarships at Epsom to give them to John Lambert Newton. We publish his appeal on page 193. The late Dr. Newton was a Bart.'s man, and his widow is Sister at the Stoke-on-Trent Hospital, and is, of course, unable to educate four children from her Sister's salary. We trust, therefore, that Guy's men with votes will consider that Mrs. Newton deserves their votes and will bestow them as Dr. Hind requests.

Pass List.

Conjoint Board.

FIRST EXAMINATION, APRIL, 1921.

Chemistry, Physics, Biology.

Chemistry.

P. M. Deville.
N. Cohen.
E. J. Clother.
W. G. Porter.
R. Jarman.
W. L. Head.
R. Franklin.
K. M. Denning.
D. A. Newberry.
H. S. Gaussen.
W. A. A. Collington.
A. Hirschberg.
W. B. Norcott.
F. F. Brayfield.
R. H. Richards.
J. C. T. Craze.
E. E. Gibson.
O. P. James.
W. E. Berwick.
J. P. L. Davies.
T. G. L. Davies.
W. Foster.
G. M. Glennie.
H. B. Kidner.
J. R. Ratcliffe.
F. A. Wilson.
E. Crocker.
S. Slotar.
G. L. Gould.
W. H. C. Lean.
R. S. Matthews.
A. R. Jackson.
A. E. Tidd.
A. H. Dyke.
J. B. Maree.
N. Parkinson.
L. J. Godden.
A. K. Van Niekerk.
M. C. Hart.
S. D. Neal.
H. E. Spencer-Payne.
J. R. Palfrey.
W. S. Brittan.
T. O'R. Clancy.
F. R. Taylor.
C. F. Shardlow.
W. O. Cooksey.
J. B. F. Tunstall.

Physics.

J. R. Ratcliffe.
S. Slotar.
R. Jarman.
W. L. Head.
W. H. C. Lean.
H. E. Spencer-Payne.
W. G. Porter.
H. S. Gaussen.
W. Foster.
A. Hirschberg.
R. S. Matthews.
A. R. Jackson.
R. H. Richards.
F. F. Brayfield.
E. E. Gibson.
A. L. Hodgkinson.
H. A. Mortimore.
F. R. Payne.
W. E. Berwick.
D. A. Newberry.
G. M. Glennie.
O. P. James.
N. Parkinson.
G. A. Sargent.
A. G. Ensor.
N. Cohen.
G. L. Gould.
H. B. Kidner.
A. Perkins.
W. H. Taylor.

Biology.

D. A. Newberry.
A. S. V. Daniels.
H. W. Lewis-Phillips.
W. G. Porter.
B. S. de Bruyn.
J. Manigard.
S. Slotar.
R. C. Evans.
H. Trafford.
I. G. Coutts.
D. R. Grant.
L. P. Tupling.
H. M. Worth.
B. P. Jones.

SECOND EXAMINTION, APRIL, 1921.

Part I.—*Anatomy and Physiology.*

W. S. Hunt.
T. G. W. Parry.
A. S. M. Douglas.
J. E. H. Duckworth.
R. R. Macintosh.
G. W. V. Parry.
C. E. Keast.
F. J. Smith.
R. E. Robinson.
W. A. Caldwell.
F. N. Newell-Roberts.
A. B. Davies.
S. C. Rowbotham.
K. O. Parsons.
G. W. Owen.
D. Vaughan.
A. R. Cox.
C. W. Greenway.

Part II.—*Pharmacology.*

R. E. Robinson.
I. R. Vermooter.
F. W. Bekker.
S. C. Rowbotham.
P. R. T. Becker.
C. L. Kark.
D. Vaughan.
H. Moore.
W. G. R. Hore.
A. Jowell (1).
S. H. Daneel.
S. M. Reeders.
A. Jowell (2).
G. E. W. Curson.

FINAL EXAMINATION.

Medicine.

G. W. Elkington.
J. T. Jones.
A. Robertson.
A. H. Shelswell.
R. J. Hodgkinson.
J. E. Wright.
L. R. A. Wells.

Surgery.

R. B. Chandrachud.
J. B. Gregor.
G. Noott.
E. T. Lloyd.
P. Couacoud.
M. Hall.
H. A. Crowther.

Midwifery.

R. B. Chandrachud.
A. Farid.
M. A. Aienger.
G. C. W. Curson.
G. B. Kirkland.
F. N. Rayner.

Bright's Contributions to Medicine.

A LECTURE BY SIR WILLIAM HALE-WHITE,
Delivered at Guy's Hospital, April 22nd, 1921.

GENTLEMEN,—My friend, Dr. Hurst, told me that he thought it might interest you to hear something of one of the greatest physicians who has ever adorned the profession of medicine, and who did all his work at this hospital. His name, as you know by the title of the lecture, is Richard Bright. I will first, for a few minutes, tell you shortly about the man. He was born in 1789, and was the son of a banker in Bristol. It was fortunate that he had independent means, for it enabled him to spend much time, as you will hear, on his general education. He went to school at Exeter and Bristol, and then, when nineteen years of age, to learn medicine at Edinburgh. He studied in that city for two years, and while he was there Sir George Mackenzie, who was preparing an expedition to Iceland, asked Bright to accompany him, partly as doctor and partly as scientific observer. Bright did this, and if you look at Sir George Mackenzie's account of his "Travels in Iceland," it is pleasing to read that he found Bright a cheerful companion, a hard worker, and his going in every way a success. He drew a few pictures for this book and gave an account of the botany and zoology of the country.

On his return he came to Guy's, and lived for two years in the house of one of the resident medical officers that they had then, and he learned medicine here. The wideness of his interest is shown by the fact that while here he read a paper on the geological strata in the neighbourhood of his native town of Bristol. About the same time he prepared a thesis, for his degree at Edinburgh, on the subject of erysipelas, which was very rife then. After taking his degree he went to Cambridge and entered himself at Peterhouse, but he records that he soon left because no one there was interested in any work. So he returned to London and became attached to the Public Dispensary, under Dr. Bateman.

But his wandering spirit seized him again, and in 1814 he went alone on a tour through Holland, Belgium, Germany, Austria, and Hungary, coming back through the Field of Waterloo a fortnight after the Battle. As I have told you, he was born in 1789, so when on this tour he was twenty-five years old. This large book (here) which is "Bright's Travels in Hungary," is a wonderful work for the age of the man who wrote it. It is excellently written. The pictures by him—I will throw one on the screen—show you what an artist Bright was. There are numbers of these beautiful plates, and the book is full of close observations, showing that nothing escaped him.

After his arrival in this country from that tour, he was appointed to the Fever Hospital as assistant physician. While there he caught fever very badly, so that he nearly died. This seems to have formed an excuse to travel still more, because he set off on a journey through Germany, France, and Italy. He came back to London, and was appointed assistant physician here at the age of 31. He remained on the active staff until he was fifty-four, when he retired, and he died at the age of sixty-eight. If any day you are passing St. James' Church, Piccadilly, go in, for on the south wall you will find a tablet to his memory. He will be best described if I now tell you of his work.

His first medical publication was this (here shown) very famous book, called "Bright's Reports of Medical Cases." His object in writing it was to try to harmonise facts found post-mortem with symptoms present during life. He said in effect: "I will write down the symptoms during life, and I will make drawings of the appearances after death and describe them, and if I do that for a good many cases I shall be able to put together similar cases, and correlate the post-mortem appearances with the symptoms observed during life." It is very satisfactory, showing what an amiable man Bright was, to learn that he excited no jealousy among his colleagues although he freely used their cases, but employed mostly, of course, his own. Thus, in his preface to this book he says: "It is pleasing, and yet no easy task, to acknowledge the kindness of those many friends who in various ways have assisted me in this undertaking. I may truly say that I have met with the most cheerful compliance in all my wishes from everyone connected with our establishment."

The first 126 pages are occupied with diseases of the kidney. Before Bright's time, of course, it must have been observed for thousands of years that people were sometimes dropsical. It was known that the kidneys were sometimes diseased. And that wayward genius, Wells, the author of the famous essay on "Dew," who was a physician at St. Thomas's Hospital, and was about 30 years Bright's senior, had written a paper on "Albuminous Urine." But these were isolated facts until Bright came along; and in the 23 cases in this volume he shows that when the patient is œdematous, the urine will contain albumen, and there will be found, post-mortem, disease of the kidneys. That was the first great step. He was well aware that minute traces of albumen may be discovered in health, but in his day it required special care to find such minute traces, for the almost universal way of detecting albumen was simply to boil the urine in a spoon over a spirit lamp and observe the coagulation.

You will like to hear about the first case of all, because it has become classical. It is that of a man named John King who was admitted into Clinical Ward, under Bright, who observed, during life, that this man, who was 34, suffered from general œdema, that he had hæmaturia and scanty urine. The hæmaturia passed away, but albuminuria persisted; the pulse was hard. The post-mortem examination revealed acute pericarditis, œdema of the lungs, pleural effusion, a large heart and ascites. "The kidneys were completely granulated throughout; externally the surface rough and uneven; internally all traces of natural organisation nearly gone, except in the tubal parts." Bright then discusses, with regard to this celebrated case and the other 22, the reasons why the œdema could not be due to disease of the heart or lungs. He points out the prevalent error of the time of regarding œdema as a distinct disease, rather than to seek for its cause, and finally he comes to the conclusion that disease of the kidneys was the cause of the anasarca, albuminuria and other symptoms in these cases. (The lecturer, at this point, threw on the screen an external view of one of the kidneys of King, from half of which the tunic is removed, showing an advanced stage of the granulated condition of the organ. (He also presented a view of a longitudinal section of the same kidney, showing that it was, in modern terminology, an example of a chronic granular kidney with partly interstitial and partly tubal nephritis.)

Here (produced) are the kidneys of Bright's second case, which was that of Mary S., aged 25, who was amditted in 1825 under him. She had œdema of the legs, albuminuria, dyspnœa, and diarrhœa. Bright tells us that the whole of the cortical structure of the kidneys was of a pretty uniform yellowish colour, with many small opaque yellowish spots.

The kidney I next show you is that of a woman, also under Bright. Briefly speaking, this is the account of her case: Mary B., 24 years of age, was admitted under Dr. Bright. She had been in the hospital several times before for œdema. She was pale and had fits. A few days before death she was seized with the particular fit from which she never recovered, remaining insensible. Here is her kidney (produced), and it is a kidney of the granular variety. Sections of it have been cut during the last few years, and it has been shown to be an ordinary case of interstitial nephritis.

Bright's next procedure was to tackle the problem in another way. Then, as now, team work was in existence. He says: I have lately had great assistance from the intelligent and zealous co-operation of three of my young friends and pupils, Mr. Barlow, Mr. Tweedie, and Mr. Rees." They examined at random the urines of 296 patients, and discovered that those urines which coagulated with heat, and also with nitric acid, were from patients who had diseased kidneys. In the paper in which Bright published details of these observations, he says that he found that a minute amount of albumen may occur in the urine in health.

A further advance was the publication in the "Guy's Hospital Reports" by Bright of two long papers on the subject, which have not been improved upon to the present day. Let me read to you what he finally said regarding disease of the kidneys, and you will agree, I am sure, with me that it is as informative as anything you will find in a text-book of to-day. He says: "A child or an adult, is affected with scarlatina, or some other acute disease; or has indulged in the intemperate use of ardent spirits for a series of months or years; he is exposed to some casual cause or habitual source of suppressed perspiration; he finds the secretion of his urine greatly increased, or he discovers that it is tinged with blood; or without having made any such observations, he awakes in the

morning with his face swollen, or his ankles puffy, or his hands œdematous. Already his urine contains a notable quantity of albumen; his pulse is full and hard, his skin dry, he has often headache, and sometimes a sense of weight or pain across the loins. Under treatment, or sometimes without any treatment, these symptoms disappear. But they come back again. His countenance becomes bloated; the skin is dry; headaches occur with unusual frequency; or the calls to micturition disturb the night's repose. After a time the healthy colour of the countenance fades; a sense of weakness or pain in the loins increases; headaches, often accompanied by vomiting, add greatly to the general want of comfort; and a sense of lasitude, of weariness, and of depression, gradually steals over the bodily and mental frame. Again, the assistance of medicine is sought. If the nature of the disease is suspected, the urine is carefully tested; and found, in almost every trial, to contain albumen, while the quantity of urea is gradually diminishing. If, in the attempt to give relief to the oppression of the system, blood is drawn, it is often buffed, or the serum is milky and opaque; and nice analysis will frequently detect a great deficiency of albumen, and sometimes manifest indications of the presence of urea. Again the patient is restored to tolerable health; again he enters on his duties; or he is perhaps less fortunate; the swelling increases, the urine becomes scanty, the lungs become œdematous, and in a state of asphyxia or coma he sinks into the grave; or a sudden effusion of serum into the glottis closes the passages of the air, and brings on a more sudden dissolution. Possibly he may be seized with an acute attack of pericarditis, or peritonitis, which will kill him in 48 hours. Should he escape these dangers likewise, other perils await him; his headaches become more frequent; his stomach more deranged; his vision indistinct; his hearing depraved; he is suddenly seized with a convulsive fit, and becomes blind. He struggles through the attack; but again and again it returns; and before a day or a week has elapsed, worn out by convulsions, or overwhelmed by coma, the painful history of his disease is closed." That, I submit, contains almost everything that is known about the symptoms of Bright's disease.

Then he discusses the treatment. He begins by saying that we cannot often cure the disease. But he recognises that, in the first place, we may use diaphoretics, which we do now. He gives, for this purpose, compound ipecacuanha powder, antimony and liquor ammoniæ acetatis; he insists upon keeping the skin warm, hence he advises that the patient should wear an inner dress of flannel, and, if he is able to do it, that he should live in a warm climate, such as Egypt. He says you may bleed the patient. We do that now sometimes for coma or convulsions. But he says you must not do that too much, or else you will weaken the patient; which is perfectly true. Cupping the nape of the neck, he states, may relieve the headache; and a few leeches to the loins may assuage the pain there. The bowels, too, ought to be kept open, and so aperients should be given. He is opposed to diuretics, as we are to-day, and will only admit digitalis. When the disease is acute he recognises that the patient should be kept on milk diet. Above everything, he says, avoid chill or the checking of perspiration. There, again, I would point out to you, everything in the modern treatment of this disease is comprehended, except that we have a better diaphoretic in pilocarpin, and that we are able to use hot-air baths more freely than Bright could.

He goes on in these papers to discuss why it is that he is able to show that the kidney is the cause of the disease. He proves that the cause does not lie in the heart or the lungs, and that the only constant post-mortem feature of these cases is disease of the kidneys.

The matter he urges most is one to which I have often directed your attention — the importance of the relationship between the skin and the kidney. If a man sweats a great deal he passes little urine; if he is passing abundance of urine he is not sweating much. In the treatment of renal disease, says Bright, encourage the secretion of sweat, because the patient is not getting rid of deleterious matters in his urine as he ought.

He points out that an excess urea may be discovered in the blood of patients with nephritis. Then he indicates other effects of this disease. He shows that there is great liability to the effusion of fluid, not only under the skin, but in the pleural and abdominal cavities. Œdema of the lungs is very common in renal disease. He observes the fact that these patients resist inflammation badly, consequently they frequently suffer from bronchitis, acute pericarditis, and peritonitis, all of which

are among the causes of death in those afflicted with Bright's disease.

He passes on to the cardio-vascular system, and emphasises that patients with nephritis are liable to hypertrophy of the heart and a hard pulse. He tells us that as regards the nervous system these sufferers are prone to convulsions and coma, that often they lose their sight, and that cerebral hæmorrhage is common. He mentions ulceration of the intestines as one of the complications of renal disease. He says that patients with this disease may die from uræmia, from cerebral hæmorrhage, from bronchitis, from pleurisy, from pericarditis, from peritonitis, or from diarrhœa. He ends the article by remarking that most of the patients are past middle life. With that he finishes his writings on the subject of renal disease.

Before we leave them I want to indicate to you what wonderful contributions they were. In a given patient you may have such an extraordinary medley of symptoms—râles in the chest, hypertrophy of the heart, ascites, convulsions, albuminous urine, œdema, and others already mentioned—with no apparent connection between them at all, until Bright arrived, and then, says he, all these symptoms are due to one thing, namely, disease of the kidneys. I submit that this is one of the most remarkable instances in the history of medicine of almost uncanny insight into the cause of a disease. The malady is so common that these symptoms were being observed every day by thousands of doctors all over the world, and yet they failed to put their finger on the one cause. Bright's account of the whole disease has not been surpassed. It is absolutely perfect, with the exception of two facts:—he could not in his day measure the height of the blood pressure, and there were no ophthalmoscopes, so that he could not detect renal retinal changes. But he knew that people suffering from nephritis had a hard pulse and went blind.

He was so anxious, however, that the matter should be beyond all doubt that he applied to his colleagues for leave to take charge of clinical wards—John and Miriam—for six months, and have nothing but cases of renal disease admitted there. He got the ready permission of Mr. Harrison, the then Treasurer, to whom this School owes a very great deal, who said, "Certainly, by all means," and Bright's colleagues were so interested that they also said "Certainly, by all means," and John and Miriam were set apart for that purpose. Bright carried out the observations, assisted by Dr. Barlow and Dr. Rees, assistant physicians, who recorded them and published them in the "Guy's Hospital Reports," and corroborated Bright's original statements in every particular.

Then Bright thought that he would go further and examine under the microscope the kidneys of a large number of patients—a most laborious thing in those days when there were no section-cutting machines, and microscopes were also poor. A Guy's man named George Robinson was to help him. He says they were going to cut one thousand specimens. Unfortunately, whether they did, or did not, nobody knows. Perhaps they did not, because no account of them was published. That exhausts all I have to tell you about the discovery of Bright's disease.

I now should like to bring to your notice other less known facts about Bright's work. Perhaps he was most interested in diseases of the nervous system; because the whole of these two volumes, the second and third of his Medical Reports, are occupied with diseases of this part, their clinical symptoms and the post-mortem appearances, and an attempt to explain the one by the other. Taking the observations in the order in which they occur, the first which arrests my attention is that of a child, aged about 5, who had what is called cerebral diplegia, that is, a condition of sclerosis of the lateral columns of the cord, depending upon some disease of the brain, varying in different cases. As you know, the child is rigid and its feet are extended. In two cases Bright observed this rigidity. One was a child, as I just said, the other was a case of tumour of the pons. When these two patients died, in both of them he observed that the spinal cord was "remarkably firm throughout, like cartilage," as it is from sclerosis. He says that he believes the cause of the rigidity—spastic paraplegia, as we call it—is the hardness of the spinal cord, which is in our present phraseology, latent sclerosis. That was his first remarkable discovery among the nervous diseases.

He was well aware that patients with cerebral hæmorrhage may have hemiopia. He records the case of a man with granular kidney who had cerebral hæmorrhage, and when writing put his finger on part of the ink that was still

wet. He gives many cases, some forty or fifty, of cerebral hæmorrhage.

Before going on to other parts of the brain, he refers to hydrocephalus, and he describes the celebrated man Cardinal, one of the most advanced cases of hydrocephalus known, the skull contained several pints of cerebro-spinal fluid. You see here the whole skeleton.

Then he gives us a remarkable case of epileptic somnambulism, that of a man living in Camberwell who walked in that state to Shoreditch, taking four hours on the journey.

We now come to a subject to which I want you to pay particular attention. You know what is meant by Jacksonian epilepsy and the doctrine of cerebral localisation. Clinical observers had noticed that when there were lesions in particular parts of the brain, particular symptoms followed. The most interesting of such cases is the group in which the lesion is on the cortex of the brain and the patient has motor seizures in the part of the body corresponding to the affected motor area of the brain. Bright was one of the very first to put our knowledge of this subject on a sound basis. He says in this book (here): "As far as I have been able to infer from my own observation, I should say that the organic causes of epilepsy, connected immediately with the brain, are more frequently such as affect its surface, than such as are deep-seated in its substance. Thus we find that morbid growth, taking place in the skull, showing itself by a thickened heavy state of bone, or by a roughened surface either internally or externally, or a remarkable prominence in the natural projections at the base, is often associated with epilepsy. Slow changes, producing a thickened condition of the membranes, will not unfrequently be found attendant upon epileptic attacks." He says that tumours may press on the surface, damaging the grey matter. Case 265 is an example: the patient a man, aged thirty-seven, liable to severe headaches, had fits, ushered in by an aura, which took the form of a tremor and cramp-like sensation in the calf of the right leg which was partially paralysed; in the fits the patient lost consciousness. The aura was so sure a herald of a fit that, when it appeared, a tourniquet "was applied at the lower part of the thigh, with the complete effect, apparently, of putting a stop to the fit." The patient experienced so much relief from the tourniquet that he kept it "constantly loose on the limb, screwing it tight when he was roused by the painful sensations usually preceding a fit." At the autopsy a tumour was found implicating the left cortex. Bright diagnoses organic change in the cranium in another case because of the "paralytic condition which remains after the attack and which never entirely subsides." He describes another case in which a man had right-sided fits. He said: "I now gave it as my opinion that these fits were owing to some local disorganisation affecting the membrances and cineritious portion of the brain on the left side. My reason for supposing that the epileptic attacks in this case depended rather on a local affection was the degree of concsiousness which was observed to be retained during the fits." So that we have clear evidence here that Bright knew that irritation of the cortex will produce fits that we call Jacksonian epilepsy, also that, generally speaking, consciousness is not lost; but the loss of it is no bar to diagnosis of Jacksonian epilepsy. And he knew that sometimes these cases had an aura, and that then peripheral stimulation may stop the fit.

Cerebral hæmorrhage naturally led him to think of aphasia, and you will find in these Reports as good a description of the common variety of aphasia as can be found anywhere. For example he gives this case. A woman had total inability of connecting her words, when she could utter them, with the ideas she wished to express, or the things to which she meant to refer. "When asked, for instance, the name of her hand, to which I pointed, she said, 'a pin,' but immediately signified her knowledge that this was not the right word, though she could not tell what the right name was." At the autopsy a cerebral hæmorrhage was found, which occupied chiefly the posterior part of the corpus striatum. "This is in accordance with an impression I have received from observation, and inculcated, with regard to the lesions which influence the articulation." Then other similar examples are given. I am sure you will agree with me that Bright was no mean observer in the sphere of nervous diseases.

We now come to quite a different thing—to what Bright writes about chorea. I do not know whether you have read a little book by Sir William Osler on "Chorea." If you have you will be aware that our knowledge of the

association of chorea with the diseases with which it is associated is largely due to the physicians of our School. As you know, rheumatic fever, chorea ,pericarditis, endocarditis, myocarditis, various skin diseases, and tonsilitis, intermingle one with another. Ample proof that the teaching of the connection between rheumatism and chorea came from Guy's is found in this book, which I show you, published by William Babbington and James Curry, in 1802. It is a "Syllabus of Lectures on Medicine" given in Guy's Hospital; on page 194, among the exciting causes of chorea, rheumatism is mentioned. Referring to the diseases associated with chorea, Bright says the association is little appreciated by the profession, and he particularly wishes to emphasise it. He says that chorea is associated with amenorrhœa, with rheumatism, with roseola, with urticaria, and he also mentions sore throat. "We also see that rheumatism is so intimately connected with chorea, that in some cases it seems to be an exciting cause, and at other times a mere concomitant." But the particular aspect of the subject to which he directed his attention was to show that chorea may be complicated by pericarditis, and rheumatism also by pericarditis, a fact which indicated that chorea was of rheumatic origin. In a paper read before the Royal Medical and Chirurgical Society he gives several instances of pericarditis in patients afflicted with chorea.

We pass on to diseases of the abdomen. Bright published a large number of cases of abdominal tumours. I think there were 117. I cannot for want of time give you any account of them, but they are well worth reading. Each case is almost a separate clinical lecture on abdominal tumour. You will find many examples of ovarian tumour attaining such a gigantic size as, fortunately, you do not often see nowadays. How far the observations that he records here are original it is impossible to say. He does not claim that any of them are. But so valuable were they considered that the profession thought it worth while to reprint them as a separate work, which I have here. Dr. Barlow, who edited this, tells us that Bright's description of hydatids was original. He says: "It is but due to the memory of Bright to state, though without any desire of imputing plagiarism to more recent continental pathologists, that the description of acephalocyst hydatids, is altogether original, and certainly an anticipation of similar observations which have since been published in Germany." There, again, is another instance of Bright's marvellous powers of observation.

His most original paper connected with diseases of the abdomen was entitled "Cases and Observations connected with Disease of the Pancreas and Duodenum." These cases—speaking of the three he records—"are chiefly intended to call the attention of the members to a particular symptom in disease which I believe to have been but little noticed. The symptom to which I refer is a peculiar condition of the alvine evacuation, a portion more or less considerable, assuming the character of an oily substance resembling fat, which either passes separately from the bowels, or soon divides itself from the general mass, and lies upon the surface, sometimes forming a thick crust particularly about the edges of the vessel, if the fæces are of a semi-fluid consistence, sometimes floating like globules of tallow which have been melted and become cold, and sometimes assuming the form of a thin fatty pellicle over the whole or over the fluid parts, in which the more solid-figured fæces are deposited. This oily matter has generally a slight yellow tinge and a most disgustingly fetid odour." (Here the lecturer showed some of the solid masses of fat from one of Bright's patients.) He then records his three cases, and shows that they all had disease of the pancreas. He says, therefore, that the passage of fat by the fæces is symptomatic of disease of the pancreas, for he excluded fat from the food. Even now our most certain sign of pancreatic disease is an excess of fat in the fæces. Incidentally, while talking of the pancreas, he says he is aware that glycosuria is sometimes present when this organ is diseased.

He wrote several papers on diseases of the liver. He taught that in cirrhosis of this organ due to alcohol, the reason why the liver varies in size is, that it begins by being large, then it contracts and becomes normal in size, and in the final stages it contracts so that it is smaller than normal. Bright was the first to really describe acute yellow atrophy of the liver. It is a disease occurring mostly in women, is associated with pregnancy; the patient suffers from fever, many cerebral symptoms, and finally sinks into a torpid condition. She is deeply jaundiced, with a great tendency to hæmorrhage. At the post-mortem the liver is found to be small, of a bright yellow colour with

many darker patches. That is the description by Bright in his paper on Jaundice. But he does not give the disease a name.

He writes a most interesting description of a rare variety of diaphragmatic hernia, which would take me too long to read.

I now come to a fairly common disease of which his description is original. He wrote a paper on Chronic Peritonitis, the object of which was to show that, in this disease, sometimes fremitus can be felt, if you put a hand on the abdomen, especially if the patient breathes deeply. That was a new symptom in his day. But in this paper he gives what I believe to be the earliest account of the disease which is now called chronic proliferative peritonitis. I will read Bright's words: "One of the most frequent morbid changes in the peritoneum is when the whole is covered with an evenly distributed false membrane, which renders it, in its general appearance, opaque, and is apt to contract the loose folds of the membrane and those by which the various viscera are suspended or attached, and likewise to form a kind of compressing ligature about all the viscera themselves; the result of which is, that the omentum gradually becomes shortened and corrugated, ultimately forming but a narrow band along the arch of the stomach and the colon—the mesentery becomes shortened, and the intestines, by this means, drawn towards the spine—the calibre of the intestines themselves becomes diminished, and they are most obviously shortened in their course—the liver is drawn close to the diaphragm and the spleen to the stomach, while the kidneys are fixed more firmly into the cavities formed by the muscles of the loins—and all these viscera are compressed in a degree which often produces alterations in their shapes. The false membrane is polished like the peritoneum, and at first sight gives the idea of a thickening and opacity of the membrane itself; but upon examination it is found capable of being removed and stripped off in large flakes, leaving the surface of the peritoneum polished and entire." There is really nothing to add to that; it is a perfect description of the condition, as good as you will find in any text-book. I pass round one of Bright's specimens illustrating this variety of peritonitis.

He foreshadowed the discovery of Addison's disease, because he recorded the case of a woman who was pigmented. She was sick and had a feeble pulse; and post-mortem he found the supra-renal capsules tubercular. Here is the specimen itself, and you are probably looking upon the earliest known specimen of Addison's disease.

I now wish to draw your attention to the question of appendicitis. (Here is a specimen of Bright's, showing ulceration of the appendix.) If you look in your books you will generally find it stated that our knowledge of appendicitis dates from 1886; none of them refer to Bright's and Addison's description. I think that is because the book ("Elements of the Practice of Medicine," by Richard Bright, M.D., and Thomas Addison, M.D.) in which it was given stopped at the publishing of Volume I. in 1839, and Volume II. never appeared. It is only fair, however, to say that Kelly, in his large work on Appendicitis, does refer to this description that anticipated by fifty years our knowledge of the disease. He says, "The description is so clear and well presented that it could not be surpassed to-day." I will read some of it to you to show how perfect it is—

"The history of the affection is as follows: The patient has complained more or less, for some time past, of pain and uneasiness in this part, *i.e.*, right iliac fossa, increased on exertion, or after neglect of the bowels, or excess in eating or drinking; he has, however, retained such a share of health, that he has not been interrupted in his daily avocations, till, after some unusual exposure to cold, some long walk, or other over-exertion, he has been suddenly seized with a more severe pain, attended with rigors, chills, and sometimes with sickness and violent vomiting. The pain and tenderness become excessive, and extend to the neighbouring parts of the abdomen. A hardness and tumefaction are soon very evident to the hand in the part first affected. This continuing, general symptoms of peritonitis often take place, and terminate fatally, but under careful treatment, the inflammation remains circumscribed and becomes less extensive, assuming the form of a local, deep-seated abscess. The threatening symptoms of peritonitis subside; the tumefaction just above the crest of the ileum on the right side is more and more obvious to the touch, and gradually shows a tendency to point, the constitution still suffering severely. In process of time it either opens of its own accord, or is assisted by the lancet." Then the authors describe the post-mortem appear-

ances, and they find that the appendix is very subject to inflammation, to ulceration, and even to gangrene; and, moreover, it is occasionally thickened, so that this little worm-like body is often detected in the midst of the abscess, with a perforation at its extremity. There you have as good an account of acute appendicitis, both clinical and post-mortem, as you could possibly desire. And yet people used to write in the papers in the eighties, announcing that the disease was quite a modern discovery, and that they had discovered it.

Bright did not pay so much attention to diseases of the thorax as to other conditions. He knew the value of oxygen. On page 226 of Volume II of his Medical Reports, he describes the case of a boy, aged fourteen. "At eleven o'clock he inhaled a bladder of oxygen gas; this was followed for a short time by longer and deeper respirations, and there was a transient amendment in the expression of the countenance, and a slight temporary redness in the face." "Oxygen gas frequently inhaled never failed to produce a temporary excitement during which the eyes opened and the respiratory muscles were called into increased action."

He records a case of heart block, which I have not time to read.

He described bronchopneumonia, and he was one of the first to describe collapse of the lung (*as differentiated from pneumonia*) when it complicates whooping cough.

I think I have given you now all his original observations, and perhaps in a few words I might tell you what strikes me most about the man. In the first place, in him the power of observation was exalted to a degree that made him a genius rarely surpassed. You know it has often been said that for one person who can see, there are fifty who can think. It is much easier to think than to observe. Coupled with this power was his great industry. When he was on the Staff he spent six hours a day at Guy's. His enthusiasm to get post-mortems indicates his industry. He told the husband of a woman suffering from cerebral disease that he did not think his wife could possibly live, The husband then decided to take the patient out, and Bright said, "I think you are quite right; I can do nothing for her here." But he added, "After she dies I hope you will allow me to examine the body." He got the consent of the husband, and in order to make the examination he had to take a post-chaise to Gravesend.

There was also his extraordinary accuracy of observation. Hardly anything that Bright said has been proved to be wrong. That is very remarkable indeed. See what Dr. Barlow says about him:—"There was one quality by which Bright was greatly distinguished, and that was his philosophic cheerfulness. He was a man without guile, who would have scorned untruth, so that he would not endure that the slightest bias should be given to any observation in favour of any particular views or opinions. This rigid and self-denying honesty in scientific investigation is no ordinary virtue."

He had an exceptional ability for writing, it reads so good. When looking through his papers I often wished that many text-books would copy Bright's descriptions of different diseases. He was widely educated. He was a skilful draughtsman, as his drawings of Hungary show. He was a linguist, a geologist and a traveller. The medical profession of the whole world admired him. The *Lancet* spoke of his death as creating a deep impression of grief and regret such as only a sense of irretrievable loss could occasion.

Obituary.

RUTHERFOORD JOHN PYE-SMITH,

Ch.M. (Sheff.), F.R.C.S. (Eng.),

Emeritus Professor of Surgery in the University of Sheffield.

Mr. R. J. Pye-Smith died on March 23rd at his house at Ampthill, and his loss will be mourned by his numerous friends who loved and greatly respected him. By his death, Guy's Hospital loses one of her most distinguished though not one of her most widely known sons.

Those who wish to read a short account of his life and work will find excellent obituary notices in the *Lancet* of April 2nd and in the *British Medical Journal* of April 9th. As his house-surgeon and, later, as one of his surgical colleagues at the Sheffield Royal Hospital, I have known him for the last eighteen years, and I should like to add a brief tribute to his memory.

I well remember my surprise when I first came to Sheffield in 1903 and found Mr. Pye-Smith's wards full of abdominal cases which, in my time at Guy's, would have been considered as belonging to the medical side. My preconceived notions as to the up-to-date cha-

racter of London surgery had to be revised; this readiness of his to absorb new ideas was one of his finest qualities, and he retained it up to the end of his life.

His surgical work was characterised throughout by an attention to detail which can only be described as meticulous. This extraordinary carefulness ensured his reputation as a safe diagnostician, but gave to an onlooker the impression of slow and rather tedious operating. Sir Berkeley Moynihan has recently expressed the opinion that a "brilliant" technique pertains to the tricks of the conjuror and not at all to the art of surgery; Mr. Pye-Smith would have been the first to agree with him.

He was one of the most even-tempered men that I have ever met, and his demeanour in the Out-Patient Department was a shining example of the power of self-control; it may be truly said of him that he suffered fools gladly; nevertheless, the student who presumed on his urbanity to try and get signed up for lectures he had not attended received a sharp and unexpected shock.

In addition to surgery, Mr. Pye-Smith had many other interests; the University of Sheffield, municipal education, the British Medical Association and the Medical Council were a few amongst the numerous objects of his mental activity; he was a firm believer in self culture, and beautiful objects of all kinds appealed to him, but, more especially, music, church architecture, painting and the scenery of mountain and moorland; he was widely read and an ardent admirer of Ruskin.

It is almost a relief to be able to record that he was not absolutely perfect. In spite of his wide outlook and singular receptivity in matters surgical, Mr. Pye-Smith was curiously conservative on a few points. He seemed to entertain a dislike to some of the so-called improvements of modern civilisation. It was a long time before I could prevail on him to accept a lift in my car, and I believe I am correct in saying that he never used a typewriter. Another weak point which must have hindered him in his work was his inability to depute the details of his surgical work to other people; he liked to dress his cases and even to apply the bandages. I only mention these small points because they help one to form an estimate of his almost excessive conscientiousness and in no way detract from his character.

On thinking over my relations with Mr. Pye-Smith, what most strikes me was his extreme uprightness; he was a deeply religious man and combined the application of his religion to the problems of life with an entire absence of intolerance: "he was to sinful man nat despitous." A younger and agnostic colleague might well have said to him, "Almost thou persuadest me to be a Christian." In his presence the use of strong language was almost impossible and the telling of a doubtful story unthinkable. His influence for good must have been incalculable and he has left an indelible impression on the minds of those who had the privilege of working with him. His epitaph might well have been—

"But Christes lore, and his apostles twelve,
He taughte, and first he folwed it him-selve."

GRAHAM SIMPSON.

Bacteriology and its Relation to Dentistry.

Paper read before Guy's Hospital Dental Society.

Mr. President and Gentlemen,—I feel rather diffident about giving this paper because I cannot in any way call myself a bacteriologist, nor can I claim any very close or exhaustive acquaintance with dental surgery. My excuse, and plea at the same time, is that perhaps I may awaken some small interest in a subject which it appears to me may materially assist in solving some of the problems which face the dental practitioner.

I do not intend to deal in any but a general way with the question, what I wish to do this evening is rather to theorise in the hope that some of the theories put forward may later help to elucidate some of the problems of mouth diseases. With actual practical methods I shall not deal at all, because I have not had sufficient experience of bacteriology, let alone dental bacteriology.

It is a subject of so much interest, and I think, practical importance, that perhaps my enthusiasm will be pardoned by those who do not see the matter in the same light as myself. My hope is that by means of bacteriology some light may be thrown on the vexed question of the causal agent of the oral diseases.

It is well known that until bacteriology threw some light on the problems in medecine and surgery that very little was known as to the actual causes of diseases. With the advent of bacteriology, however, the whole question began to present a different

aspect, and now practically every disease is known to be caused by its own specific micro-organism. It must be remembered that to prove unquestionably the relation between micro-organism and disease three things are necessary. First the organism must be isolated from the person suffering from the disease; second the organism must be grown in pure culture outside the body on artificial culture media; third the disease must be reproduced by animal inoculation with the prepared pure culture.

I need only mention in passing, a few examples of the important part that bacteriology has played in disease. Take enteric fever as an example—the isolation and proof of the B. typhosus as the causal agent of this disease has made possible the preparation of vaccines which, given prophylactically, have so raised the body resistance that infection afterwards has been rare or if acquired has been much less severe in its manifestations. Most people here to-night have probably had numerous injections of T.A.B. vaccine whilst in the Services and will appreciate what I mean.

Take just one other example—the isolation of the Klebs-Loeffler bacillus in cases of diphtheria and the proven fact that the danger to life was by means of its potent exotoxin has made possible the preparation of an antitoxin by immunisation of horses, and injection of this immune serum has been the means of saving innumerable lives. One could of course give numerous other examples, but I think these two will suffice.

Now is there any reason why bacteriology should not play just as important a part in solution of the problems of the oral diseases? At present our knowledge of the causal agents of nearly all the common mouth diseases is practically nil. If any of you will take the trouble to look at a text-book on dental surgery you will find a chapter devoted to the bacteriology of the mouth. I guarantee that most of us are just as wise when we finish the chapter—if we do ever finish it—as when we started. It consists, as far as I can make out, of a heterogeneous mass of unpronounceable names of various micro-organisms with no definitely proved relationship to any of the mouth diseases, with a few exceptions.

What is first needed, in my humble opinion, is a complete new classification of the common mouth bacteria, to find out which are pathogenic and which are merely saprophytic. After all the mouth is an ideal incubator, and it is but natural that it should be swarming with bacteria, but that does not necessarily mean that any or all are pathogenic. The whole alimentary tract is swarming with bacteria, but no one has yet suggested that they are all pathogenic. This classification will take an enormous amount of time and patience, but I think it is the first necessary step.

It is not outside the realms of possibility that a new classification would reveal the fact that many of the so-called normal mouth bacteria are only pleomorphic forms of micro-organisms already well known. If this could be proved it would certainly simplify matters a great deal.

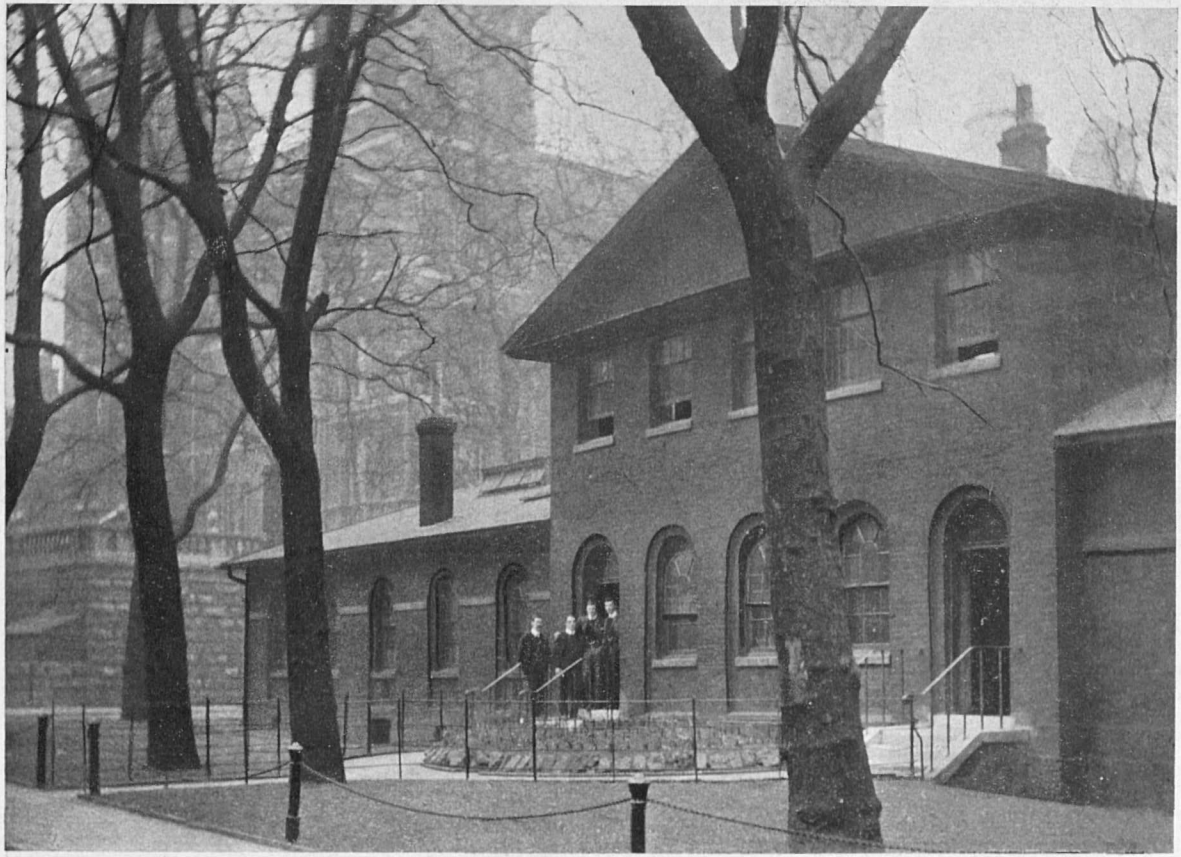
Now to commence with the commonest dental disease, namely, caries. It has been unquestionably proved by Miller that caries is at any rate partly the result of the attentions of the bacteria found in saliva. You all know the chemico-parasitic theory of caries and how it can be produced artificially, so I need not go into it. What is proved is that given an acid medium, carbohydrates and saliva, caries can be produced. It seems, therefore, that the mouth bacteria are partly the exciting cause of caries, but what is not yet proved is whether there is some predisposing bacterial cause elsewhere than in the mouth. Is there, for instance, some predisposing cause to be looked for in the intestinal tract without which caries could not normally arise?

May I digress here a moment to tell you of an incident that struck me forcibly at the time. It happpened in Constantinople some months ago. I was sitting in my laboratory when a Greek civilian came in, carrying a specimen tube containing fæces and a "chit" asking me to examine the stool for cysts of the "Entamœba Histolytica."

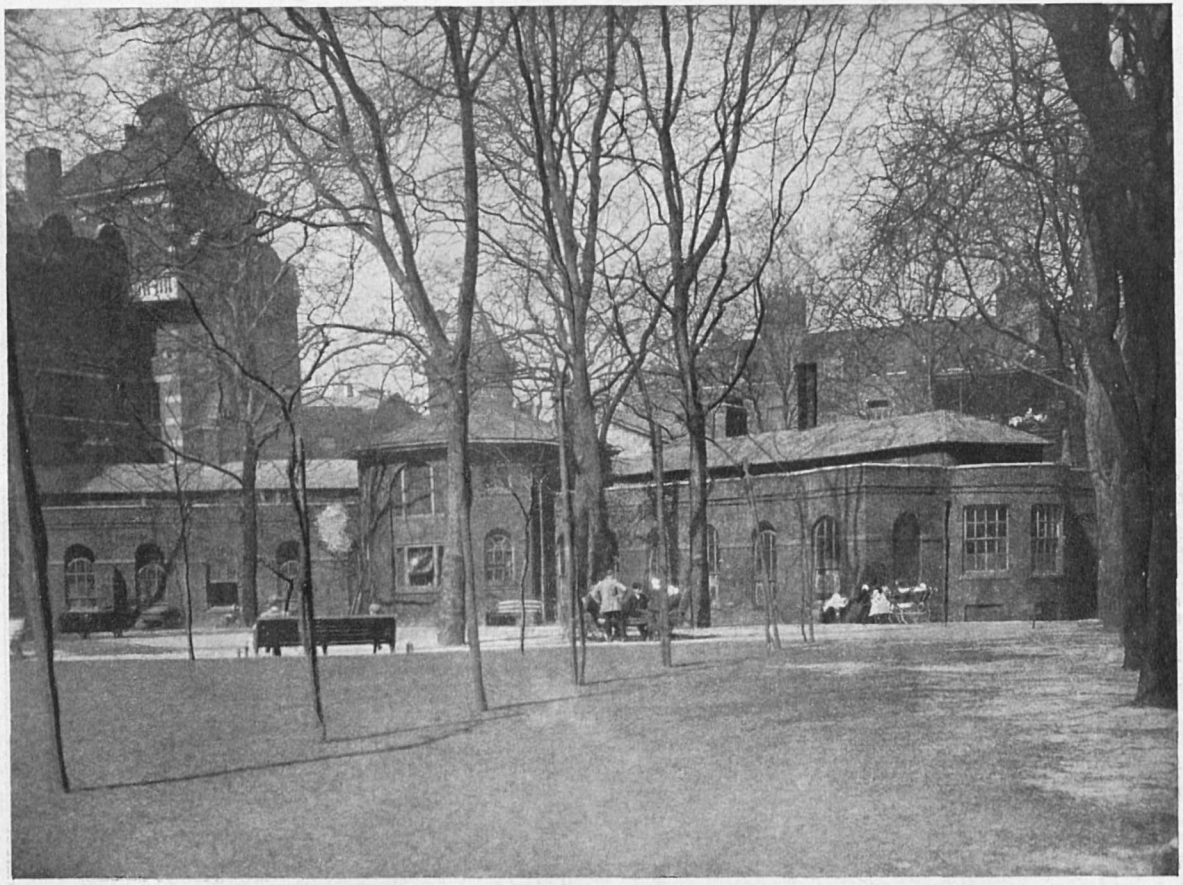
I happened to stain a smear from the fæces by Gram's method, and then noticing that the man's mouth was particularly dirty I took a smear from around the teeth and stained that in the same way. I was then called to the telephone and when I came back I examined both slides. Well, I simply could not tell one from the other—both had apparently been taken from the same place. It seemed that that Greek was the possessor of two rectums—one in the usual place and one with teeth in it!

What struck me then was whether the dirty condition of the mouth could have been caused in any way by the bacteria normally passed in the fæces, because the smear from the dirty mouth seemed a replica of that from the fæces. It therefore seems possible to me that the common oral diseases may have their predisposing causes in the circulation of "master toxins" produced in the intestinal tract. Possibly the action of these toxins is to so lower the the general resistance that bacteria which before were non-virulent, or only moderately so, became very virulent. In fact, would oral disease be possible if there were no circulation of master toxins in the blood which would affect all tissues and secretions, even the saliva?

May I give you the history of a case of which I was told which gives some colour to my argument. I am harping on this rather fully because I think that the bacteriologist who would solve the causes



CLINICAL WARDS, Front View. *For this Photograph we are indebted to Miss STRICK.*



CLINICAL WARDS from the Park. *(For this Photograph we are indebted to Miss SMITH.)*

of oral diseases, must look farther afield than the mouth.

A man came up to a certain laboratory and an examination of his sputum showed numerous tubercle bacilli to be present. A specimen of fæces was also examined and it was found that there were enormous numbers of a particular brand of streptococcus present on cultivation. It was thought that possibly the "master toxins" produced by these streptococci had been the cause of the man's lowered general resistance, making possible the invasion by the tubercle bacillus. A vaccine was therefore prepared from cultures of the streptococcus and was given at the usual intervals. Well, the result was that the tubercle bacilli disappeared from that man's sputum and his condition was vastly improved. In other words the predisposing cause of the tuberculous condition was the toxin produced by the streptococcus, though of course, the exciting cause was the tubercle bacillus. Whatever one's views on the subject there is food for thought here.

To harp back to the questions of caries I would be inclined to go rather further than this and say that three things may be necessary for the production of this disease. Firstly, the circulation of toxins produced in the intestinal tract; secondly, an interference with the calcium metabolism, due in some way to the endocrine glands—both predisposing causes; thirdly, the fermentation of carbohydrate foodstuffs by the acids of the mouth, and by the acid forming proleolytic bacteria in the mouth.

If, on the other hand, we consider that the mouth diseases are always primary then we must satisfactorily prove that certain micro-organisms or groups of micro-organisms do actually produce the various pathogenic conditions found in the mouth.

Another point of interest is the question of immunity. At present there seems no immunity to the common dental diseases in any person in any civilised community, and in this connection it would be interesting to see if there was any agglutinative power in a patient's blood serum against his own mouth bacteria.

Just think of all that could be done if we could prove, say, that pyorrhœa alveolaris was due to a specific micro-organism. Firstly, we could increase the patient's immunity by raising his opsonic index by the giving of vaccines, *i.e.*, active immunity. Secondly, we could immunise animals against the disease and so produce immune serum to the infecting bacterium, which could be administered to the patient, *i.e.*, passive immunity. Thirdly, we could inoculate other people with a prepared vaccine and so prophylactically immunise them against the disease.

I would, in conclusion, draw your attention to a method of treatment of diseases which it seems to me might be applied in conditions such as pyorrhœa for example. When a cell is damaged by bacterial infection one of the things which happen is the upset of the normal electro-motive force of that cell. Now could we reinsulate that cell so that this escape were stopped that cell would be in a position to tackle the infecting micro-organism whatever it might happen to be. Apply this principle to the treatment of pyorrhœa. Could we but dry the gums, pockets, etc., and then cover them with a dielectric substance such as lipoid paraffin the damaged cells would regain their normal electro-motive force and the infection would be beaten. It would not matter what the infecting organisms were, as all are, alike to the reinsulated cell. Anyone can prove for themselves that there is something in this theory. The next time anyone gets a boil or carbuncle, for instance, get it opened and then apply a dressing soaked in l paraffin—that is paraffin with a certain percentage of the lipoids cholesterin and lecithin. I think you will find that the boil or carbuncle will clear up much quicker than if you carried out the ordinary treatment with fomentations. I can only quote this method as an almost complete amateur, though I have tried it in some cases and was struck by the almost startling results.

Finally, I hope that I havn't bored you all with this paper, but I do most emphatically think that there is a great scope for bacteriology in dentistry. It is only, however, by the closest co-operation between the dental surgeon and the bacteriologist that any results will be obtained, and it will take much time and patience, and probably will be disappointing at first. Still it is worth while I firmly believe.

Papers by Guy's Men.

Alan H. Todd, M.S., B.Sc., F.R.C.S. Recurring Dislocations of the Shoulder.—Proc. Roy. Soc. Med., xiv., Orthop. Sub. Sect. 147, 148.

—— Case of Recurring Bilateral Dislocation of the Patella.—*Ibid.*, p. 152.

W. E. Tanner, M.S. Case of Osteo-Chronditis Deformans.—*Ibid.*, Clinical Section, p. 57.

Philip Turner, M.S., and L. Mandel, M.D. Submammary Tumour of the Chest Wall.—*Ibid.*, p. 60.

W. H. Ogilvie, M.A., M.Ch., F.R.C.S., and Grant Massie. Two Cases of Dupuytren's Fracture Treated by Screws.—*Ibid.*, p. 63.

Change of Address.

Arthur Stanley Herbert, O.B.E., M.D., B.S.Lond., 1, Upper Phillimore Place, Kensington.

W. H. Grace, M.B., M.R.C.P., 66, Gloucester Crescent, Regent's Park, N.W.1. Hampstead 5234.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

The Business Side of Medical Practice.

DEAR SIR,—Will you allow me to enter an emphatic protest against Dr. Hollist's strictures on the B.M.A. in your last issue of the GAZETTE.

The B.M.A. represents 52 per cent. of the entire medical profession and between 80 and 90 per cent. of the profession in active practice. It is not supposed officially to represent the views of the profession; very far from it. Dr. Addison recently, whilst Minister of Health, desired to meet a body of men who did. But in practice there is no association of medical men whose views are held with greater respect than the B.M.A. amongst both Parliamentarians and Civil Servants.

Might I be allowed to give three out of many instances that occur to me.

(1) In the bad old days before 1911, clubs were rife. The club doctor contracted to attend weekly wage earners and others for sums varying from 2s. 6d. to 4s. per head. On the introduction of the Insurance Act Bill, it was first proposed to continue this slavery. The B.M.A. organised us, and "after making a certain amount of noise," Parliament granted us 9s. per head to include drugs and dressings, as against the 4s. of the club doctor. This was accepted by the profession, with the exception of a few malcontents. This sum has since owing to the rise in the cost of living risen to 13s.

(2) The organisation of the temporary officers of the R.N.M.S. and R.A.M.C. was initiated by the B.M.A., and though eventually the composition of the Central Medical War Committee became somewhat altered, the whole of the work was carried on to the termination of the war by the machinery of the B.M.A., to whom the Government voted £5,000 in recognition of its services.

(3) The Dangerous Drugs Regulations. The strenuous opposition by the B.M.A. to the regulations which it was proposed to thrust upon the profession have now been deeply modified by a contrite Home Secretary and his satellites of the Civil Service.

So much for its political side. Might I be allowed to add that this is only one branch of its work, the others—the social, the scientific, the journal are without parallel. Last year probably exemplified the two former at their best at the Annual Meeting at Cambridge.

In conclusion might I ask those of you are now qualifying to follow the advice of Dr. Lauriston Shaw (as I did twenty-one years ago) and join the B.M.A. Be active members in it, attend their meetings, scientific and social, divisional, branch and central. Learn from us the political and ethical sides of our profession. You will learn much, make many lasting friendships, and lastly by your activity you will do much to help on the great causes of our profession.—Yours faithfully,

C. EDWARDS.

Granville House,
Bridport.
May 8th, 1921.

Please Return Diagnosis.

DEAR SIR,— Once again I should like to draw attention to the growing slackness of certain Out-Patient Departments in returning P.R.D. cards with the correct diagnosis or some helpful remark on them. If the staff would only realise that these cards are the sole means of helping ignorant dressers and O.-P.O.'s to confirm or confound their original diagnosis, I am sure that they would see to it that more of these cards found their way back to the Surgery and fewer into the waste paper basket. It ought to be the duty of the clerk to each Out-Patient Department personally to see that the cards are returned to Sister Surgery day by day.—Yours faithfully,

DISAPPOINTED.

Guy's Hospital, S.E.1.
May 5th, 1921.

The War Memorial.

DEAR MR. EDITOR,—I would like to congratulate Dr. Ryle on taking up the cudgels against the proposed inscription on the War Memorial and you for your support if his protest.

As to alternatives, I cannot trace "the words which were proposed in Passim some weeks ago" to which you refer in yours of April 30th, and I agree with you in your objection to the proposed latin motto. "Their name liveth for evermore" seems to me colourless if used alone with no special allusion. It is probable that any phrase chosen will be a copy of one used elsewhere, and if this is admitted could anything be better than the epitaph on Waggon Hill above Ladysmith:—

Tell England, you who pass this monument,
We died for her and rest here well content.

For the word "here" is surely permissible under poetical licence. I am not sure that my contemporary, Mr. E. D. Bascombe, to whom greeting after many years, has not made a better suggestion in your last issue, unless it be thought too long; it has a distinct reference to the occasion which my suggestion lacks.—Your faithfully,

C. H. FAGGE.

3, Devonshire Place,
Portland Place, W.
May 2nd, 1921.

Admission of Dental Pupils to Guy's.

Dear Sir,—I regret that Mr. H. R. Codrington Butler feels aggrieved by the contents of the circular letter sent from this Office to old Guy's Dental men. May I put the following points to him and your readers?

During the war, all the Dental Schools were practically empty. With the cessation of hostilities and gradual demobilisation, they have become overcrowded. A disproportionate number of men who had completed their training in Dental Mechanics obtained Ex-service Students' Grants from the Board of Education. The School felt it could not refuse the appeal of the Board to come to the assistance of those who had risked their all in the Country's service, and so it came about that the Clinical period contained as many students as the School could possibly accommodate, most of whom were in their third year of study.

It must be clearly understood that, when admitting students to the Dental Prosthetics Laboratory for their training in Dental Mechanics, the School undertakes to provide for them the complete four years' curriculum. Many of these students have obtained war concessions from the Conjoint Board, and so have been enabled to pass the first Professional Examination six months earlier than had been anticipated. In this way, the number of students in the Clinical period has been still further increased.

More than a year ago, the Dental Council, fully alive to the dangers of overcrowding, discussed the possibility of increasing the accommodation available for third and fourth years students. Owing to difficulties over which the Dental Council has had no control, it has not yet been possible to effect any alteration. The Dental Council, therefore, has been reluctantly compelled to decide that no students who have completed their training in Dental Mechanics elsewhere than in the Prosthetic Laboratory of this School, could be admitted during the present term, or in October, 1921. The present position, however, is purely temporary, and it will soon right itself.

It is confidently anticipated, that in May, 1922, the Dental Council will be able to admit a certain number of students who have completed their training in Dental Mechanics elsewhere than in the School, and that, in October, 1922, it will be possible to admit all such men as have any Guy's connection. As soon as it is possible to foresee how many vacancies there will be at those dates, a further circular letter will be sent out.

Mr. Butler may rest assured that no students are more welcome at Guy's than the sons, relatives, and pupils of old Guy's men, and, indeed, there are many such in our School at the present time.—Yours truly,

T. B. JOHNSTON,
Dean.

Medical School,
Guy's Hospital, S.E. 1.
May 11th, 1921.

Guy's Hospital Ladies' Association.

The 26th Annual Meeting of the Guy's Hospital Ladies' Association was held in the Court Room, on Tuesday, May 10th. Lord Goschen presided and there was a large attendance, 185 members being present. At the conclusion of the general business Lord Goschen thanked the members, on behalf of the Governors, for the sum of £1,125 which they had subscribed and collected, in various ways during the year. This sum is to be distributed as follows:—

£400 for the support of eight beds in the Maternity Ward.

£25 for the support of a cot by the Junior Members.

£25 on behalf of the West Herts Junior Members to support a cot.

£100 from the South Norwood Members of the Forest Hill Branch to support a cot for four years.

£25 for the support of a cot by the Banstead, Sutton and Orpington Branch.

£50 on behalf of the Hornsey Branch to start a Cot Endowment Fund.

£500 for the endowment of a cot by the London Members in commemoration of the first twenty-five years work of the Association.

All these cots to be in the New Childrens' Ward.

At the end of the Meeting several hundred garments made and contributed by the Members were exhibited. Tea was given by the Governors, and Members and their friends were then taken round to the wards and various departments of the Hospital, the centre of interest being the Childrens' Ward.

Further help is urgently needed, and anyone interested in the work of the Hospital is invited to join the Association. All information will be given by the Hon. Secretary.

Notices.

EPSOM COLLEGE FOUNDATION SCHOLARSHIP.

Your votes and interest are earnestly requested for a Foundation Scholarship for John Lambert Newton, born June 3rd, 1911, eldest son of the late Francis Morley Newton, M.R.C.S., L.R.C.P., London, who died February 15th, 1920, aged 45 years. He was at the time of his death, and had been for ten years Medical Officer to the Stoke Union Infirmary. He left a widow and four children aged 8, 7, 6, and 1½ years. He suffered from asthma and diabetes, so was unable to insure his life or make any provision for his family. Votes will be gratefully received by Mrs. Newton, Stoke Union, Newcastle, Staffs.

Reviews.

A Physical Interpretation of Shock, Exhaustion, and Restoration: An extension of the Kinetic Theory. By G. W. Crile, M.D. (Messrs. Frowde, Hodder and Stoughton.) 232 pages, 120 illustrations. Price 25s. net.

Professor Crile has worked himself, and inspired others to work, at the problems of shock for over 20 years. His previous contributions to the subject are numerous, important, and well known. And we welcome any further publication of his on a subject, which is of the greatest interest to anæsthetists, surgeons, and laboratory workers, and of the highest importance to anyone who is unfortunate enough to suffer from trauma whether scientifically carried out or otherwise.

In this volume Prof. Crile reviews the main of his earlier publications, incorporates some of the results of his war experiences in France, adds the findings of new experiments, and submits the data to a theoretical consideration. In the later chapters he indicates how his experimental results and theories may be applied to surgical practice, and propounds rules for particular classes of operations.

The amount of experimental work carried out by the author and his co-workers is enormous. On one aspect, viz., the electrical conductivity of various organs in normal and in shock states, he informs the reader that the conductivity of 4,798 sections of various tissues has been determined, that this material was obtained from 436 rabbits and 137 clinical specimens, and that the work is still in progress! Histological examinations of brain, cerebellum, liver and adrenal, appear to have been carried out on a similar scale; while the varieties of animals dealt with include electric fish, salmon before and after their 1,000 mile run up the Columbia River, porcupines, skunks, armadillos, woodchucks, hibernating and awake, birds and reptiles, in addition to the more usual laboratory animals and clinical material. It must have proved a very difficult task to set forward the main results of all the experiments in a book of this size, a book, moreover, which is copiously illustrated; and we often wish for fuller experimental detail and less picture.

In the first section of the book the immediate results on the blood pressure and respiration, produced by trauma of different parts of the body under varying conditions, is clearly set out in composite diagrams averaging the findings of many experiments. Here the absence of deleterious effects under local anæsthesia is strikingly depicted, and it was results of this nature that seemed to give the author the "key to the shockless operation" through anociation. The idea that all shock could be avoided if all afferent impulses were cut off from the central nervous system is one of Prof. Crile's cherished beliefs. The idea underlies a great deal of his work, and is categorically stated on p. 190: "In both the laboratory and clinic it has been shown that shock cannot be caused by any amount of trauma upon an area physiologically severed from the brain by a local anæsthetic." If this statement is wholly true then much other work is pointless and many other theories are valueless. In this book we can find no experimental evidence to prove the assertion, and we believe it is much stronger than the facts warrant. However, with this view it was a natural step to try and determine if any characteristic microscopical changes could be demonstrated in the brain during the shock state.

The second part of the book deals with this point and is illustrated with many photomicrographs. The long array of animals previously noted was subjected to "shock or exhaustion producing stimuli" and their organs submitted to careful histological examination. In all cases varying degrees of cell change were noted from hyperchromatism, through chromatolysis, to cell death and neuronophagia. Here we must note that shock and exhaustion seem to the author synonymous terms. Thus on p. 65 "In other words, emotion may cause *exhaustion;* it may cause *shock*," and on p. 77, "That is, electric stimulation may cause *exhaustion;* it may cause *shock*," and so on. It appears that trauma, toxins, emotion, electric stimulation, anaphylaxis, lack of sleep, and infections, all produce the same effect on the nervous system and give rise to exhaustion or shock. Perhaps the clue to this similar result from such diverse causes is to be found in the statement of p. 82, "We found in every instance the same cycle of changes—the same histologic evidence of exhaustion, *provided and always provided* that the animal lived for two or more hours in shock or exhaustion before the specimen was obtained." Dare we take a liberty and alter a few words? Provided and always provided that the animal *survived* for two or more hours *with a very low blood pressure* before the specimen was obtained. The grosser changes depicted in the photomicrographs might easily be due to impaired blood supply, while the minor changes are not very convincing. It is not clear why sections of the cerebellum and Purkinje cells are used so often to show these changes and not the cells of more important nuclei in the medulla.

Alternative explanations of the root cause, and the manifold phenomena of shock, receive scant treatment at the hands of the author; for example, the recent work showing the importance of the capillary dilatation and stasis might have received more attention. It receives passing notice and is attributed to Cannon. In fairness it must be said, however,

that Prof. Crile states in his preface that he does not intend to review the literature.

In the following sections the book becomes yet more theoretical and speculative. The mode of action of the master tissue, the brain, is considered and we find Prof. Crile's flights of imagination difficult to follow when our "dull brain perplexes and retards." As far as we understood it, the nervous impulse is believed to be an electric current inducing as it flows magnetic disturbances in the white matter. These induced disturbances in the white matter form the basis of memory, and the suggestion is made that they also supply a reason why the tracts in the brain decussate while the bones do not, neither do the vessels. This pure electrical conception of the nervous system suggests once more the loss of electrical energy from raw surfaces, and explains the value of oily and fatty dressings for large wounds. This idea of electrical leaks as far as we are aware has not the slightest experimental support. In this section and that on the part played by the ductless glands we must confess that we often do not follow the argument, sometimes it is impossible to do so, as when iodine, iodoform, and iodothyreoglobulin appear to be regarded as one substance.

Nitrous oxide-oxygen anæsthesia is warmly advocated and quotations are made from Dr. Marshall's work in France, but surely it was not necessary to rechristen our Assistant Physician and name him Major Gregory Marshall.

In the final section of rules for surgical procedure the experience of the author as an experimenter, and as a surgeon, triumph over his theories. The rules appear to be a very valuable part of the volume, and the statistics for consecutive operations on the thyroid show well nigh perfect results:—206 thyreidectomies with one death from double pneumonia, 87 ligations without a death, and no case refused for operation, form a great testimony to his rules. Mention may be made here of the great value of ice packs in hyperthyroidism following operation, which is illustrated on p. 196.

The book is stimulating and compels thought, and there are suggestive phrases such as, "touch-and-go operation," "feather-edge technic." We realise, as never before, after reading this book that surgery is always interference.

For the experimental results, the practical conclusions, and for the energy and enthusiasm which has inspired Prof. Crile and through him his pupils, to work so industriously at this subject, we have the warmest admiration. Even if we do not agree with the theories, which have changed from time to time and will change again, the experimental work remains, and it is that which guides Crile as a surgeon and will guide others.

The book is admirably got up, well printed, and the illustrations are clearly reproduced on good paper.

Medical Science, April. (Messrs. Humphrey Milford.) Monthly, 3s.; Annual Subscription, 30s.

Reviews: Jordet gives four cases of parotid swelling due to obstruction of Steno's duct caused by irritation set up by the wearing of a tooth-plate. Brüning gives statistics of 300 gastric analyses in children. He finds that the total acidity increases in proportion to the age of the child.

Hurst finds that the type of stomach, in which gastric and duodenal ulcers respectively are found, is congenital.

Raymond describes cases of pyloric spasm, and states that they are fairly common. Many reviews are contributed of work on Tumours of the Abdomen and miscellaneous abdominal conditions.

The mortality, ætiology, symptomatology, and treatment of diphtheria are exhaustively studied from many sources.

There is a systematic review of several cases of spasmodic contraction of arteries of medium size after causing secondary hæmorrhage and gangrene.

Non-tuberculous juvenile coxalgia is discussed, and an interesting case of anterior dislocation of the elbow is described.

The extracts from works on bacteriology, pathology and radiology are too numerous to describe.

There is a very interesting paper on the physiology of pain. The author is not satisfied by the complacence with which the philosopher, viewing pain from the human point of view, ascribes to pain a disciplinary function, and he is impressed, as a biologist, by the enormous discrepancy between the amount of experienced pain in the world and any observed physical, mental or moral benefit to the sufferer. He regards the preponderance of pain over other sensations as a survival of the premordial mode of sensation. He suggests that pain is only just not present in us all, and what appears to be only an insignificant disturbance pathologically may prove an effective and incurable exutant of it.

Angina Pectoris. By Walter Verdon, F.R.C.S. (Messrs. W. T. Moulton & Co., Brighton.) Price 18s. 6d.

Many writers on Angina Pectoris have laid emphasis on its close association with gastric disturbance. In this book the writer attempts to show that the cause of anginal pain is muscular spasm of the gastro-œsophageal part of the alimentary canal. "High intragastric pressure," he says, "in the presence of hyper-irritable segmentary and vagal centres is an agency possessing potentialities, efficient

in the production of anginous seizures, and in the determination of sudden death, which occasionally ends them."

He discusses the anatomical and physiological considerations in favour of this theory, and subsequently compares the clinical features of a simple vomiting attack with those of an attack of angina; he points out that salivation, swallowing movements and fixation of the respiratory muscles accompany both kinds of attack, that sweating pallor and other evidence of vaso-constriction are common to both, and that in both relief follows the expulsion of stomach contents whether air or food. Exercise, he contends, may bring on an anginal attack because it causes a rise in intragastric tension, and not because it raises the blood pressure.

The book contains a very useful section on treatment; the dietetic treatment may be criticised on the ground that the allowance of meat is too liberal.

Many will disagree with the writer's theory of the pathological basis of angina, but everyone will admit that it is one of extreme interest, and that the book contains a very able defence of it.

Diseases of the Skin: A Text Book for Students and Practitioners. By J. M. H. MacLeod, M.A., M.D. (Messrs. H. K. Lewis & Co., Ltd., London.) Pages XX + 1307. Illustrations, 23 in colour and 435 in black and white. Price £3 10s. net.

The publication of Dr. MacLeod's book on Diseases of the Skin is a matter of real importance to British Dermatology. There are many dermatological text books, but this one, far more than any other in the language, is of definite value to the student, the practitioner, and the skin physician himself. One remembers the feeling of boredom with which, as a student, one attempted to gain some understanding of skin diseases from the text book descriptions. One was left with the impression, which is still widespread, that dermatology was mainly a matter of elaborate terminology whose minute subdivisions were a subject suitable for discussion between academic and unpractical pedants. Dr. MacLeod,s book has the special merit of showing the study of cutaneous diseases to be a most fascinating and important one.

There are one or two text books which are quite good up to a point. But there is no work in English which is so thoroughly satisfactory, as the one under review. It is sure to become the standard British text book.

It is the work of a very learned and experienced dermatologist, who has evidently taken immense pains to produce a book which shall be worthy of his speciality.

The descriptions, both clinical and pathological, of the various diseases are extremely well written, and leave a clear picture on the mind. They are full, but no irrelevant matter is introduced. They are particularly valuable in that they insist on the fact that dermatology is not a matter merely of nomenclature and pedantic diagnosis, but that the skin is one of the most important organs of the body, and that its morbid conditions are closely interdependent on those of the whole individual.

Perhaps the illustrations are the most outstanding feature of the book. They are uniformly excellent. The coloured plates are good, but are overshadowed by the remarkable collection of photographs. These fulfill the real purpose of dermatological illustrations, which is to refresh the memory of diseases which have been previously studied in the living subject.

One of the best sections in the book is that on Syphilis, which gives a refreshingly clear and unhackneyed account of the cutaneous manifestations. Here, as elsewhere, the pictures most ably amplify the text.

There are, of course, many statements of Dr. MacLeod's which can be criticised. As a Guy's man one is bound to complain that the author refuses to distinguish between seborrhœic eczema with secretory staphylococcal infection, and true impetigo contagion. This distinction is of the greatest importance, but is apparently still not acknowledged except at our own hospital.

There is, however, very little to find fault with in a work which is without doubt the best English text book on Diseases of the Skin.

The publishers have done their work excellently.

The Early Diagnosis of Tubercle. By Clive Riviere, M.D., F.R.C.P. Third Edition. (Messrs. Henry Froude, Hodder and Stoughton, Oxford University Press.) Pages xvi.+318.

In these days when the more dramatic methods of treating tuberculosis are proving abortive, or at least less successful than their optimistic champions imagined in the first tide of their enthusiasm, it becomes all the more necessary that the general practitioner should acquire a mastery of the methods involved in making an early diagnosis as a preliminary to hygienic treatment. The average newly qualified man, who leaves a general hospital for general practice, has had few opportunities of seeing tuberculosis in its early stages; indeed he knows less, perhaps, about tuberculosis than any other common disease, and this is the more unfortunate as it is the disease of which he will see the most.

The modern tendency is to treat everyone as tuberculous until he can prove that he is not. This tendency towards hasty diagnosis is almost as unjustifiable as neglect to recognise active and progressive disease. Beset, on the one hand, by the pessimist who, light-heartedly hurls the miserable,

though perhaps healthy, patient into the remorseless mechanism of modern T.B. administration which, once set in motion, grinds the patient through the hospital, then through the sanitorium and finally ejects him to face the world with a millstone round his neck. And, on the other hand, by the optimist, who, in face of repeated hæmoptysis, emaciation, crepitations and all the typical features of active tuberculous disease, talks glibly about varicose veins of the throat, weakness of the chest, and all the rest of the dreary catchwords. The practitioner seeks, in his despair, a trustworthy authority which will set him on the right path. It is all the more to be regretted, therefore, that Dr. Clive Riviere's book, "The Early Diagnosis of Tubercle," is inadequate in some respects. Taken section by section, little can be found to say in criticism of most of them; taken separate, as a whole, there is more to cavil at. Since there can be no active tuberculous disease without constitutional symptoms, one might expect to find especial prominence given to them in a book on early diagnosis since, apart from the finding of tubercle bacilli in the sputum, they are the only evidence which can stand almost alone, as evidence of tuberculous *disease*, as distinct from tubercular *infection*. Yet only seven meagre pages are devoted to symptomatology, while 40 pages are given up to the use of tuberculin in diagnosis and space proportionate to the latter on Rontgen rays, special laboratory diagnostic tests and so forth—features of great importance indeed, but of subsidiary importance in the diagnosis of active disease. Dr. Riviere insists that the high road to diagnosis lies in the physical examination of the chest. While accepting this with obvious reservations, it is to be doubted whether the best way to encourage the practitioner to rely on his physical examination, is to terrify him by the recital of the multitudinous pitfalls which await him. I venture to suggest that the lung reflex of Abram and some of the other sources of error quoted, would utterly shatter his confidence in his own findings.

Although it appears grossly unfair to criticise the author for including them, since their omission would be misleading, the criticism is justified by the prominence which they are given and because they are included as essentials in physical diagnosis, when their importance is, as yet, not fully conceded. Apart from this, the chapter is a masterly exposition of an art, of which the author is such an able exponent.

Dr. Riviere also includes a chapter on hilum tuberculosis, the condition so dear to the heart of the radiologist. The book is divided into two sections: Tubercle in the adult and Tubercle in children. Owing to the compression of the latter, the various elements in diagnosis assume more or less their relative proportions, and it is therefore a very valuable section.

In the Preface the author heralds the further revision of the book and intimates his intention of excising albeit reluctantly, some of the less valuable diagnostic methods. Let us hope that by expanding certain sections and ruthlessly pruning others he will succeed in making the book the well-proportioned volume which the excellence of its material merits.

Public Health Chemical Analysis. By Robert C. Frederick and Aquila Forster, Ph.D., M.Sc., A.I.C. (Messrs. Constable & Co.) Pages 305. Price 21s.

In this book the authors have dealt solely with the Chemical part of Practical Public Health.

After the usual, but unnecessary, introduction to laboratory methods, which is here unusually good, there is a section on air analysis of some 46 pages. Haldane's apparatus for the estimation of CO_2 in air is described with great clearness and detail, and the Pettenkoffers' and the Lunge-Beckendorf methods are given only a short description. The Haldane apparatus for general air analysis is also given prior claim. It is a pity that the only illustration of this somewhat complex apparatus is a photograph with all the taps invisible in deep shadow.

The next section concerns Water, and is clear and concise. The section is not burdened with too many methods of doing the same thing, the selected methods being certainly the most accurate, and the author's view as to the uselessness practically of the dissolved oxygen test, included for completeness, is most acceptable to practical analysts. The pages on interpretation of results with comments on typical analyses are distinctly useful.

Sewage and Trade Waste is next dealt with, receiving but six pages, which, however, contain all that is absolutely necessary.

The analysis of milk and cream is described at great length, and all the usual methods with their common variations included. Butter, margarine, lard, and cheese are next touched on, and the Reichert—Wollny—Polenske process receives all the attention which is due to it.

The treatment of grain analysis is good, but the micro-photographs of starch granules have only one point to commend them—that of an uniform magnification. The sugars are next in order. The methods of estimating pure sugars and every probable commercial mixture of sugars are very well described, much better, in fact, than is usual in Public Health Manuals.

Proprietary foods, rice, and alcoholic liquids come next. Some average analyses would greatly improve this section, the methods only being given. Tea, coffee, cocoa, mustard, pepper and vinegar are next treated, and the section on food completed with a good description of the detection and estimation of metallic poisons liable to be found in food.

The remaining ten pages deal with disinfectants, soap, and rag flock.

The book is decidedly one to recommend to all who want to take their laboratory work seriously and not just as a necessary evil in the D.P.H. curriculum, its greatest drawback being its seemingly excessive price.

An Atlas of Normal Labour. By G. Drummond Robinson, M.D., B.S., F.R.C.P. (Messrs. William Heineman, Ltd.) Price 25s. net.

This volume illustrates natural childbirth by a series of photographs from kinematograph films which were made under the author's direction, partly from life and partly by the reconstructive method familiar to patrons of the "Movies."

That the subject of normal labour is one of paramount importance is now beginning to receive tardy recognition. Any publication which seeks to present accurate and detailed information on its many problems is worthy of a hearty welcome so long as it claims to supplement, and never to supplant, the lessons learnt by actual attendance at the bedside. The author hopes that this Atlas may prove of use to those who teach and study the processes of parturition, but no doubt its main purpose is to emphasise the possibilities of the direct appeal to the eye of the Kinematograph as a medium of instruction. It is difficult to gauge the future of the Kinematograph in medical teaching, but there is every reason to suppose that it will soon become a necessary adjunct to the Lecture Theatre. As its success will depend upon the meticulous accuracy of its portrayal of the subject dealt with, no pains must be spared to produce films which are above criticism. The deeply rooted faith of the past generation in the printed word has died hard, but that "the camera cannot lie" is accepted generally as a truism.

Regarded as a pioneer attempt to supply a real need, Dr. Robinson's "natural" films are excellent though there are flaws in the surgical ritual which we deprecate. The animated diagram series we cannot so wholeheartedly praise, owing to certain glaring anatomical inaccuracies which could have been avoided.

We congratulate the author and his publishers on breaking new ground in such a creditable manner, and we commend the Atlas to our readers. We also venture to hope that Medical Schools will give to the producers of medical films the support to which they are entitled.

The American Year Book of Anæsthesia and Analgesia for 1917—18. Price $10.

This publication has made a late appearance owing to the exigencies of the war. By reason of this, however, a great deal of interesting material has been collected, related to advances in anæsthesia, occurring during and on account of the war and its special necessities.

Reports are included on almost every conceivable subject which can interest the anæsthetist. These reports include chapters on the clinical aspect, the pharmacological, physiological and pathological aspects of questions which arise in this branch of work.

The majority of articles are by American workers, but there are also chapters by British authors, among whom are Dr. Shipway, Dr. Pembrey, and Dr. Geoffrey Marshall, whose papers have appeared on previous occasions in British publications.

One value of a book of this kind is that the reader does not get only the views and deductions of one author, but those of many, on the same subject. This fact involves occasional differences of opinion, which enable the reader better to crystallise his own thoughts on a subject where there may be plenty of room for argument.

The chapter on Nasal Administration of Gas and Oxygen in Dental Surgery is particularly interesting, but the apparatus described and illustrated is far too unwieldy for use in private practice, however satisfactory its results may be. In hospital practice, however, it should be admirable.

Manson's Tropical Diseases. Seventh Edition. (Messrs. Cassell & Co., Ltd.) Price 30s. net.

This is a new edition, thoroughly revised and considerably enlarged, although the actual number of pages is slightly less than in the last volume.

There are many new and excellent plates and wood-cuts. The subject of tropical fevers has extended to twenty-three chapters, and a new chapter is devoted to the enteric group. The influence of the war in increasing previous knowledge of tropical diseases is seen throughout the volume. In the series of appendices is a notable addition incorporating Laboratory Methods and details of Protozoology and Medical Zoology, which should be valuable to the isolated worker in the tropics, as the author intends. A practical chapter on animal poisons, such as snake-bite, is also introduced.

With its additions it should prove a useful and convenient Tropical Manual.

Barrier Charts for Health Officers. By S. H. Daukes, O.B.E., D.P.H., etc., Wellcome Bureau of Scientific Research. (Messrs. Baillière, Tindall and Cox.) Price 3s. 6d. net.

This publication represents a new idea in the teaching of preventive medicine. The author has grouped the communicable diseases under four heads according to their mode of spread. To a remarkably

extensive example of the familiar lists of diseases and their incubation and allied periods, he has added columns describing the modes of defence of the individual. The use of two-colour printing emphasises the individual and the social aspects, no less than those of the general practitioner and the salaried preventionist. The student, faced by the equal prominence given to rare and to more common diseases, will scarcely find these charts a short cut to his goal. The practitioner, particularly if engaged on official public health work, will find presented in a clear form the various modes of combating the spread of disease.

A Handbook for Nurses. By J. K. Watson, M.D. Edin. (The Scientific Press, Ltd.) Price 10s. 6d. net.

The new edition (sixth) of this popular book should be very much appreciated by those interested in the nursing profession.

The enormous amount of information it contains is so well arranged that one becomes thoroughly interested instead of, as so often happens, bored by page after page of tabulated facts.

Over two hundred pages have been added and the number of illustrations, which are very clear, more than doubled. New chapters have been added on the Symptoms of Disease, on Electricity and Massage, on Ear, Nose and Throat Affections, on Skin and Venereal Diseases.

Every chapter has been revised and brought up to date, and the book should keep its place as one of those most useful to nurses.

Treatment by Hypnotism and Suggestion or Psycho-Therapeutics. By C. Lloyd Tuckey, M.D.Aberdeen. Seventh Edition. (Messrs. Baillière, Tindall and Cox.) Price 21s.

This book consists largely of a detailed description of the various disorders which may be benefitted by hypnotic suggestion. A ponderous list of cases is cited which have been cured by this form of treatment in the hands of the author and other workers.

Brief mention is made of the inherent possibilities of auto-suggestion in the treatment of certain ailments, but unfortunately this theme, which has never been fully investigated, is dismissed with the statement that success here can only be achieved by a few. The contention that a disease usually dominates the system, and, therefore, prevents the presence of a state of mental receptivity and confidence essential to curative auto-suggestion is probably fallacious, for the subconscious mind is completely amenable to control by suggestion and will be influenced by it, although the reality of the assertions is not objectively believed.

The author quotes cases which he believes to disprove Freud's assertions that there is always a sexual origin of phobias. He, in addition to most English authors, fails to realise that phobias may develop years after the original sexual experience, being usually excited by some more obvious factor which is erroneously regarded as their basis.

A chapter on treatment by suggestion during the war by Dr. Percy Allan has been inserted into this work, and contains some interesting information.

The book, as a whole, will prove to be of some value to those studying this subject for the first time. Others, however, will look in vain for any advance in a subject which has wallowed for years in a state of stagnation.

Aids to Dental Surgery. By D. Gabell, M.R.C.S., L.R.C.P., L.D.S.Eng. 3rd Edition. (Published by Messrs. Baillière, Tindall and Cox.) pp. 132. Price 3s. 6d. net.

Gabell is responsible for this edition as, since the last edition we have to record the deeply regretted loss of Prof. Underwood. This little book is very complete and, as an aid to Dental students, should be useful in revising their work.

Swimming Club.

A distinctly hopeful meeting was held at Hoxton Baths, Shoreditch, on Wednesday, May 4th, at 7.30 p.m. There were over twenty members present, consequently team races and a water polo game were able to take place. It was noticed that one or two new members showed a considerable amount of promise and if they (and this applies to all others) will try and practice, places in the first and second teams will be found for them.

Owing to the coal strike it is hard to find a bath where everybody can practice regularly, but if members will turn up to Lavington Street Baths at lunch time, the second class bath—the only one in use there—will be found at liberty for all enthusiasts.

Everybody is asked to watch the Notice Board, and suggestions will be gratefully received by any member of the Committee.

GUY'S v. EALING.

On Friday, May 6th, the first fixture of the season was swum off at Ealing. This match consisted of a team race, four a side, and a water polo game.

In both events our opponents were superior, in team race (two lengths each man) Guy's lost by 2 yards; time being 2min. 33 2-5th secs. The Water Polo match being the chief event was well contested,

Cohen opening the score by throwing a beautiful shot in the first half. The teams crossed over with Guy's leading, in the second half two long shots managed to beat Sampson, who played a wonderful game at goal. Time came with the score 2 goals to 1 against. The two most conspicuous players during the evening were O. Painter and C. A. Wakeford, the former playing a wonderful game the whole time.

For the first fixture this was a most creditable performance, as Ealing has always been known as one of the strongest swimming clubs in London.

It is with great regret that the match against St. John's, Cambridge, had to be scratched owing to the coal strike; it is hoped that this match will be played at a later date, as two fixtures were arranged.

United Hospitals Swimming Club.

This club has been re-formed this year and has been exceedingly lucky in getting Sir Alfred Fripp as President.

Notice of the other officers will be given at a later date.

The first trials are to be swum off on Friday, May 13th, at 4 p.m., at Hoxton Baths, Shoreditch.

Fixtures with leading clubs are being arranged. The most important event this season is the Gala night to be held on July 1st at the Bath Club, from 8 p.m. to 10.30 p.m.

Through the influence of our President, the Bath Club Committee has kindly consented to allow the Club the use of their Bath the evening after the Inter-Varsity swimming sports.

At this meeting the Inter-Hospital Swimming Cup will be swum off. The events being Team Race, 1 length, 50 yards, 100 yards races, also the Water Polo and Diving Cups will be competed for. It is hoped that at the same time an Inter-Hospital Nurses Race will be arranged. The following handicap events for all hospitals will also be swum off, 1 length, 2 lengths and 3 lengths, also a two lengths level back race.

The Amateur Diving Association have kindly consented to give an exhibition of Fancy Diving, and the Otter and City Police Clubs are being approached to play a polo match during the evening.

Two shillings entrance fee will be charged for all Open Handicaps. Application to be made to Hospital Swimming Secretary. Entries close on June 20th, 1921.

No charge will be made for admission to the Bath Club, but only those people who are fortunate enough to secure tickets, which are limited to 300 (ladies and gentlemen), will be admitted.

Application for tickets may be made to the Club Secretary, or to each Swimming Club Secretary of any Hospital.

Spectators must enter by the Berkley Street entrance.

Further particulars will be issued later by poster and also in the Guy's Hospital GAZETTE.

R. JARMAN, *Hon. Sec.*

Athletic Club.

The Annual General Meeting was held on Friday, May 6th, Dr. Fawcett in the chair. Twenty-five members were present. The following Officers were elected for the year, 1921—22:—

President—Dr. Fawcett.

Hon. Treasurer—W. K. Fry, Esq.

Hon. Secretaries—Messrs. L. G. Housden, S. V. Strong.

Committee—Messrs. G. Craze, P. K. Albertijn, M. E. M. Jago, A. S. Gough, J. D. S. Thomas, A. W. Greenway, J. A. Currie, K. J. Davies, L. K. Watson, W. D. Doherty, A. H. Shelswell.

Before the next issue of the GAZETTE is published, the University of London Sports will have been held at Queen's Club on the 25th inst., and, it is to be hoped, Guy's will have won the Cup. A number of entry forms will be found on the notice board in the Colonnade and intending competitors are asked to fill them in and send them off to Mr. Hyder at King's College Hospital. The trials for the "relay" team will be held shortly and those who wish to be coached in hammer throwing and putting the shot should write their names on the paper fixed to the notice board, where the time and place of the first lesson will be announced. High and long jumping may be practiced at H.O.P., and the quarter-mile track, if not already marked out, will be so within a few days.

The Hospital Sports will be held at Honor Oak Park, on Wednesday, June 15th.

Appointments.

J. F. H. Stallman, M.B., B.S., M.R.C.S., L.R.C.P., re-appointed Surgical Registrar to the Hospital for Sick Children, Great Ormond Street.

Birth.

ELLIOTT.—On May 10th, 1921, at Stokenchurch, Bucks, to Mabel, wife of E. Lionel Elliott, M.B., B.S.Lond., a daughter.

Death.

MOYLE.—At Brookfield, Woodway Road, Teignmouth, South Devon, Reginald Moyle, M.R.C.S. Eng., L.R.C.P.Lond., late of St. Briavels, Glos.

STURGES-JONES.—On May 7th Ellen Blake, wife of W. E. Sturges-Jones, in her 51st year.

ED.—A. T. R.

GUY'S HOSPITAL GAZETTE.

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Passim.

WHY is it that that part of Great Maze Pond which runs between the College and the Surgery remains one of the roughest roads in the whole of the Borough?

In taking this as a text for the grumbling sermon which tradition seems to demand each fortnight in Passim, we will probably call down indignant denials from high Olympus of the importance of this matter, or at least of the ability of the powers that be in the Hospital to alter the condition of the road. It will, perhaps, be pointed out that road-mending is the concern of the Borough Councils and not of the Board of Governors. It was with the hope that we might call the attention of the Hospital Authorities who in their turn might influence the Borough Councils that we embarked upon this laboriously written paragraph. For it certainly is a terribly bad piece of road, as anyone can prove that will ride up and down it on a bicycle (preferably on one borrowed from the externs). The externs themselves wax eloquent in the strongest of language when questioned upon their views about this road.

Consider now the many ways in which this road interferes with the smooth current of Hospital life. Firstly it runs immediately below the windows of Hunt's House. Often when going round the Medical Wards with physicians or registrars we have found it almost impossible to follow their learned discourse. This was in part due to the drowning of their voices by the noise which was caused by the jolting of carts passing along Maze Pond. This noise never entirely ceases, for even in the small hours carts are passing along on their way to and from the Borough Market. Lying awake at night we have heard them rumbling by and have been quick to notice the sudden diminution of the clatter when the carts left the rough part for the well made road outside the Surgery. How much more then must this disturb the sleepless patient who lies awake in Mary or in Addison? Secondly, we would ask you to watch the next motor ambulance you see making its way at full speed down Maze Pond to the Surgery. Notice the way in which it is flung up and down and from side to side by the unevenness of the road. Surely, this is not the best treatment that can be offered to patients who are being hurriedly brought to the Surgery in a shocked condition.

Thirdly (or perhaps as this is a sermon we should say—thirdly and lastly) think of the poor extern. Imagine him getting a card in the middle of the night, having to get up and dress hurriedly with the prospect of a frantic ride through drizzling rain down to Spa Road or some other equally inaccessible, and at that

hour, equally unwelcome, neighbourhood. He rushes down, mounts his bicycle, and then with tyres half deflated, and saddle badly sprung, goes jolt, jolt, jolt, down Maze Pond. Do you wonder that he arrives at last at his destination in a perfectly awful temper, and do you blame him if he finds it necessary to make a prolonged call at the Surgery for sustenance when he returns, before he attempts again the perilous journey down Maze Pond?

If this road were only a smooth, well-made one, think of all the things that would have been saved—the patients' rest—the night nurses' worries—all the quantities of sleeping draughts used in Hunt's House—all the bottles which break mysteriously in the externs' bags—the springs of the ambulances—the tempers of their drivers—and lastly this long column in Passim.

One side of Maze Pond is in Southwark the other in Bermondsey. The Hospital owns property in both boroughs. The Councils of both boroughs have embarked upon extended programmes of road mending. Would it not be possible for the Hospital authorities to get the ear of the Councils and to induce them to send some of their roadmakers down Maze Pond?

WE publish in this issue a letter which Sister Esther has received from one of her old patients expresssing her gratitude for the care taken of her in Hospital. The letter, though not free from mistakes of grammar, of spelling, or of style, yet reflects that deep respect in which the Hospital is held by the whole of the Borough. How often have we been told by Borough mothers in no half-hearted and in no flattering tone, "I dunno, doctor, what we should do without the 'Orspital." Though all patients do not express their thanks as profusely, nor do they all endorse their thanks as this patient has done by subscribing to the ward funds, yet this spirit of gratitude runs widespread throughout the district which the Hospital serves. May we long continue to deserve these thanks and this respect!

A NOTICE has recently been posted in the College forbidding the housing of any motor bicycles in the College bicycle shelter, other than those belonging to men resident in the College. This has caused some little discontent among certain men, who now, owing to transport difficulties, have found it convenient to come up to the Hospital each day by motor cycle. They have hitherto been leaving their machines in the College, more or less under the shelter, which has been quite inadequate to deal with the increased demand made upon it. It was in consequence of this overcrowding that the notice was posted. The attitude which is taken up by the motor cyclists is that, being members of the Clubs Union, they should have free and equal use of this shelter with the College residents, whom they have no desire to evict. If this is impossible they plead that some shed be erected in some part of the Hospital precincts where they may leave their machines in shelter and in safety.

ON page 211 will be found a notice of two lectures on general practice which are being given by general practitioners, and which should prove of the utmost use to students. In view of the correspondence which has recently appeared in the GAZETTE asking that some such instruction should be given to students who are about to qualify and to encounter untutored the many small difficulties which beset the practitioner when first he begins to practice, these lectures should be well attended. The first, which will be given on Tuesday, June 7th, by Dr. P. Seymour-Price, is a general lecture upon general practice. The second is the lecture on record keeping which we were promised some months ago, but which

through a badly chosen hour, and insufficient advertisement produced so poor an attendance that it had to be cancelled. We hope that all men will make a point of turning up at this lecture so that Dr. H. M. Stewart may feel that the trouble which he has taken to prepare this lecture, and to come twice to the Hospital to deliver it has not been taken in vain.

We learn that Dr. Mutch is relinquishing the position of Secretary of the Students' Club. His successor will be Mr. Lane Roberts. We regret that Dr. Mutch has found it necessary to resign from his secretaryship for under his guidance the affairs of the Club have been running very smoothly. From time to time we heard voices raised in protest against minor inconveniences, and there is always someone or other who would have redress against the caterers, but these protests would exist under the most perfect regime. We have no doubt that Mr. Lane Roberts (whose capacity for organisation has been demonstrated by his able work with the Guy's unit of the Special Constabulary) will prove to be a most efficient secretary. He will find many opportunities for reform and improvement and we feel sure that he will make the most of these opportunities, and that the College will be a better place to live in after he has taken it under his supervision.

It has been the custom now for several years for bibliographies of prominent Guy's men to appear occasionally in the Gazette. Thus lists of the works of men such as Wilks, Targett, Arbuthnot Lane, and Pye-Smith have been published as records of their painstaking energy in teaching and in research. The last bibliography the Gazette published appeared in 1919, and recorded the works of Dr. Goodhart. In this issue we publish a bibliography of Sir Frederick Taylor. His works, published from 1871 to 1918, have been collected together by Mr. G. A. Winston, the Wills Librarian, who is to be thanked for the care he has taken in compiling and completing this bibliography.

During the past winter the Hospital did very well in all the competitions for the Challenge Cups in the various winter sports. We were in the final games of every competition, and we won more of the final events than we lost. Already we have begun to compete in the summer competitions. On Tuesday last the First Cricket XI. beat the University College Hospital. Scores:—

1st innings, U.C.H., 70
Guy's, 174
2nd innings, U.C.H., 187 for 5
Guy's, 84 for 4

The Second XI. defeated University's Second team with equal facility (their score was 253 to their opponents' 41).

On Wednesday the University of London Athletic Sports took place. The Rosebery Cup was won by University College, Guy's being second, five points behind. An account of the sports will be found on page 215.

The Boat Club, on Thursday, rowed against Bart.'s a race of coxwainless fours. Guy's won by three and a half lengths and thus retain the Rowing Cup.

Guy's Hospital Dental School.

The following Scholarships and Prizes have been awarded:—

Entrance Scholarships in Dental Prosthetics.—Internal Scholarship of the value of £30, Mr. J. R. A. Moore. *External Scholarship.*—No award.

Operative Dental Surgery, 1921.—*Prize,* of the value of £10, awarded to Mr. D. A. Parsons. *Certificates* to Mr. H. F. Miles and Mr. H. Greaves.

Prize in Dental Subjects for Fourth Year Students, 1921.—*Prize,* of the value of £10 awarded to Mr. M. Braun.

Prize in Dental Subjects for Third Year Students, 1921.—No award.

Some Affections of the Jaws.

CLINICAL LECTURE BY MR. E. C. HUGHES.

GENTLEMEN,—Throughout the year I have in my beds quite a number of cases of diseases of the jaws and I thought it would be worth while to consider some which arise in connection with the teeth, whether as a result of errors in development or as a result of sepsis. Let us first consider some of the tumours that arise as a result of developmental errors, and to understand these we must first revise the development of the teeth. In the embryo a thickening occurs in the epithelium along the line of the future mandible, and a continuous downgrowth of this tissue takes place, this downgrowth being known as the dental tooth-band or lamina. From the labial side of this downgrowth the temporary teeth are laid down, the epithelial ingrowth being invaginated over the subjacent mesoblastic tissue. This invaginated epithelial ingrowth is known as the enamel organ, and there is one for each temporary tooth. The enamel organs for the five anterior permanent teeth arise on the lingual side of the temporary, as a continuation of the dental lamina, those for the molars arise from posterior continuation of this lamina. The enamel organ becomes more and more invaginated, enclosing the mesoblastic tissue to a considerable degree. The enamel organ gives rise to the enamel, while the partially enclosed mesoblastic tissue, the dental papilla, forms the rest of the tooth (see diagrams in Mummery's *Microscopical Anatomy of the Teeth*). There is a large amount of epithelium between each enamel organ, and between the overlying epithelium and the enamel organ that is not used by the developing teeth, and it is from this waste epithelium that tumours known as the epithelial odontome, the follicular odontome and the dental cyst arise.

The follicular odontome (or dentigerous cyst) is an innocent cystic tumour arising from the dental epithelium and connected with an unerupted tooth. They arise about the period of eruption by proliferation of the cells of the tooth band or enamel organ. Some cause prevents the normal eruption of the tooth, and the proliferation and degeneration of the cells continues to an exaggerated degree, the fluid collecting about the crown of the tooth. The tumour increases in size, but is always enclosed by an epithelial wall.

This type of odontome is equally common in both upper and lower jaws, and the teeth most frequently affected correspond with those which most commonly fail to erupt. Gabell, Warwick James and Lewin Payne in their "Report on Odontomes," have found in a large series of cases, that the canine is far most frequently at fault, then the incisors, followed closely by the wisdoms. They note the average age of the patients to be 15, the eldest being 30. All their cases were in connection with permanent teeth with the exception of four.

Dental cysts are innocent simple cystic tumours arising as the result of irritation of the dental epithelium about the root of a tooth which has undergone eruption. In glancing at the development of a tooth, we saw the enormous amount of waste epithelium, some of which can always be found about the roots of a tooth. As a result of irritation of these cells, from sepsis of the tooth, the epithelium proliferates and forms at first a solid mass, later on the central cells degenerate and liquefy, and in time there is formed a large fluid cyst with a definite epithelial wall.

In extraction of a tooth there is occasionally found attached to the root a small rounded body which used to be called a "pus sac."

This "pus sac" is now known as an epithelial root tumour, and is the early stage in the overgrowth of the epithelium: it is actually a collection of epithelial masses, which undergo a central degeneration and liquefaction.

Dental cysts only occur in connection with permanent teeth, and have been found according to the "Report on Odontomes" in patients up to the age of 56.

The signs and symptoms of follicular odontomes and dental cysts are so similar that in describing one condition, we are practically giving a description of the other; and it is only to be expected when we remember that both conditions are cystic and arise in practically the same situation.

There appears in the affected region a rounded painless swelling, at first small, hard, and bony, and later on larger, softer, and fluctuating.

The swelling originates within the bone, and as it expands the bone the overlying bone becomes thinner, until eventually it becomes so

thin that there is egg-shell crackling. In the body of the mandible the swelling is always at the expense of the outer surface, while in the ascending ramus the expansion affects the whole process. In the upper jaw the swelling is nearly always on the facial surface of the maxilla, and as it increases in size it encroaches on the antrum of the Highmore, and may bulge into the nose or cause a palatal swelling.

These clinical signs of the two conditions are identical, the points of distinction are

1. In the follicular odontome there is normally a tooth missing. This helpful sign may be absent if there has been extraction of teeth and no dental history, or if the cyst arises in connection with a supernumerary tooth. In the dental cyst there may be a septic root, or more commonly the patient gives a history of dental inflammation, for which extraction has been done.

2. The history of a dental cyst is not uncommonly one of a primary dental inflammation, perhaps recurrent and of some duration, for which dental treatment has been given, and then some months or even years later a swelling appears and slowly increases in size in the same position.

3. The X-ray evidence. In the follicular odontome, in the wall of the cyst, or in its interior is seen the unerupted tooth, generally malplaced or deformed, while in the dental cyst there may be seen the offending root, but more frequently there is no abnormality other than the cyst.

I have here the skiagrams of four cases of cystic distension of the ascending ramus, the clinical signs of which were very similar; one of them is a follicular odontome and the others are dental cysts.

The history in all but one was an increasing painless swelling of the cheek, one being so striking that it was called a parotid tumour. By handling the swelling from within and outside the mouth, it was possible to get fluctuation, or failing that, egg-shell crackling.

It is striking that the follicular odontome was in a woman æt. 59; she is leaving the hospital to-day. The three dental cyst cases were edentulous, with no noticeable inflammatory history except in the case of one, a man who had been attending Mr. Hopson for acute trouble with his teeth. Mr. Hopson, after dealing with this trouble, had found this cystic expansion of the ascending ramus. Operation was advised, but all pain and inflammation having subsided, the patient preferred to wait. He attended a year later with a discharging wound just in front of the massetive insertion into the mandible, saying that since his last visit he had two or three acute attacks, which had subsided, but that on the last occasion an abscess had formed and burst on the face. These three cases were all treated by an external sub-maxillary incision, and by exposing the external surface of the ascending ramus; the extremely thin scale like external bone was removed, and the entire epithelial cyst wall removed. The Follicular odontome case was treated in the same way and the tooth, the wisdom, removed.

The advantage of this method of treatment *i.e.* the external incision is the short period of treatment, the patients usually being discharged in 8 days.

I have skiagrams and models here showing these two unilocular epithelial cystic conditions in various positions.

There remains to be considered the epithelial odontome, which is known by many other names, the best being the multilocular cyst of the jaw.

This odontome is an innocent tumour arising from the dental epithelium with the formation of numerous cystic cavities.

There is an enormous overgrowth of the waste epithelium, producing a solid mass inside the mandible, the central cells then degenerate and liquefy forming numerous cysts throughout the swelling; these cysts at first microscopic, may in time, by coalescence of neighbouring cysts become nearly as large as a tangerine orange, though as a rule they are much smaller.

I have here a skiagram of the jaw of a woman aet. 23, who came to my out-patient department last Monday, she has obvious mandibular swelling, and on examining its outer surface, there is in the molar region an external progration with eggshell crackling; in front there are three bluish areas where the outer bony covering is missing: in these areas the cystic condition is attached to the mucous membrane of the gum. The slow growth of this tumour—it has already been present nine years—is displacing the teeth and if left to itself will invole larger and larger areas of the mandible.

Some of these specimens from the museum show a different clinical type, where, probably as a result of sepsis or incomplete operative interference, there is a fungating mass projecting into the mouth; but still in the deeper parts of the specimen the tumour retains its multilocular cystic condition.

This odontome is commoner in women than men, and much more common in the mandible than the maxilla.

The "Report on Odontomes" says the earliest case was aged six months and the oldest seventy-five.

The clinical aspect of the case varies with the duration of the odontome, and the rate of growth, though slow, appears to be steady.

It produces horrible disfigurement and disability, and calls for treatment in the early stages, when the disease is limited.

Time prevents me from dealing with two inflammatory results of dental sepsis, examples of which are in my beds now; one is the general hypertrophy of the gum, and the other is the hyperostosis or overgrowth of the maxilla, beginning in the alveolar margin.

Obituary.

ARTHUR S. TAYLOR,
B.A. (Camb.), M.D., F.R.C.S. (Eng.)

Dr. A. S. Taylor died on April 7th after a mastoid operation, and his sad and sudden death, coming as it did in the midst of his work, will be greatly mourned by his many friends and contemporaries at Guy's.

He passed the M.B., B.Ch. examination in 1887, and held the appointment of House Physician at this Hospital. He obtained the F.R.C.S. in 1888 and the M.D. in 1893.

During the war he was a Captain in the 2nd Surrey Volunteer Corps, and a Visiting Surgeon to the Kingston District Red Cross Hospital, and to the Oakenshaw Auxiliary Hospital.

We offer our sincere sympathy to Mrs. Taylor in her bereavement.

Appointments.

W. Arthur Young, M.B., B.S., Pathologist to the St. John's Hospital for Diseases of the Skin, Leicester Square, W.C.

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Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

The Clinical Laboratory.

DEAR SIR,—May I encroach on the valuable space of your influential organ to express the general disgust of those engaged in the wards re the unseemly chaos of the so-called "Clinical Laboratory"?

Many months ago the Pupils' Physical Society, recognising that individual effort was foredoomed to failure, sent a mass protest on this subject to the administrative authorities of the Hospital. After some parley, the secretaries of this Society were referred to the Medical Instruments Committee and, I believe, received vague promises of a half-time laboratory attendant, and an adequate supply of material.

Three months have elapsed since then, yet on recently inspecting this blot on the fair face of Guy's, I was amazed to find that there was:—

1. No distilled water.
2. No urinometer.
3. Broken centrifuge.
4. Insufficient reagents to carry out the most elementary tests of urine and other excreta.
5. A few bottles containing ancient dregs of bacteriological staining reagents.

How can we boast of a hospital which by its inertia fails to provide means for any keen ward clerk to work efficiently? Whereas the state of the Medical block is deplorable, that of the Surgical section is considerably worse. Here we have no laboratory at all.

As a much harassed "Take-in" Dresser I well remember having to beg a hæmacytometer and slides from one medical ward, the diluting agents from another, a microscope from the College, and eventually a drop of blood from the patient in the surgical block. Having returned to our famous clinical laboratory I found, of course, no Leishman's stain, and had, therefore, to continue my peregrinations to the Bacteriological Department. With completion of the investigation it was necessary to retrace my previous steps, unburdening myself of borrowed material en route. By the time that this journey was completed, the R.S.O. had commenced to operate on the case preferring the risk of leukæmia to the boredom of waiting!

This condition exists owing to (1) invidious distinction between medicine and surgery with which our thoughts are saturated from the first moments in the wards; (2) a perverted sense of economy.

EXHAUSTED.

Dear Sir

I Received your receite for the £1 note and your complements and thank you) and my Husband and me wishes to thank the docters and nurses and the Sister of Ester ward for their kind attention and kind ways and kind words which we shall never for-get I would have wrote before but I had a bad hand would you still be kind to me and give this letter to Dr Bull the Dental Department.

Yours truly,

Mrs. WATT.

Hilda Watt laid in bed 23 Ester wards.

Notices.

Summer School of Civics.

The programme of the Summer School of Civics (to be held this year at Guildford, Surrey, from 30th July to 13th August) has been much developed and extended as a result of experience gained in previous years, and now offers opportunities for all-round social study which should appeal widely to teachers, social workers, and organisers.

The courses of lectures to be given fall into three classes. In the first course, those on Geography, Descriptive Economics, Primitive and Present Day Institutions, Anthropology, and Modern History; through these the student will be given a condensed but comprehensive view of community life at the present day. In the second class are the courses which develope a theory of community life in its various aspects—those on Social Biology, Social Psychology, Social Philosophy, Economic Theory, Art as a Social Study, and Sociology. In the third class come the courses on the Principles and Practice of Civics, on Social Education, on Public Administration, and on Economic Problems, with a special course for Health Workers (Organised by the National League for Health, Maternity and Child Welfare), on the Welfare of Infants and Young Children, and another for teachers on Modern Developments in Education. This class covers the field of civics considered (not as a narrow study of government and politics, but) as the Art of Community Life—the definition current in the Civic Education League.

Students will also find much that is interesting and valuable in the Classes on Presentation of Civics (Public Speaking, etc.), in the informal discussion which will be, as formerly, a great feature in the School's work, in the Exhibition of Civics and Rustic Surveys and Housing and Town Planning Schemes, in the Survey Walks and Excursions in Guildford and neighbourhood, and in the Library and Bookstall.

Among the lecturers will be a number of those already well-known in connection with the Summer School of Civics, such as Mr. F. J. Adkins, M.A., Mr. A. Farquharson, M.A. (who will be responsible for the general direction of the School), Mr. G. H. Green, B.Sc., M.B. Litt. (author of the recently published "Psychanalysis in the Class Room," Miss Norah March, B.Sc. (Editor of "National Health"), Miss E. M. White (Lecturer on Civics, L.C.C.), and Mr. Harold J. Peake, and several new lecturers, among whom are Mr. Morris Ginsberg, M.A., (of the Philosophy Department, University College), and Capt. J. H. Menzies, are giving their services this year. The Inaugural Lecture will be given by Professor Patrick Geddes (Professor of Sociology and Civics in the University of Bombay) who is now generally recognised as the world-authority on Civics. Professor Geddes has also promised his assistance in connection with surveys and exhibitions. Special lectures on Psycho-Analysis are being given by Miss Barbara Low, B.A., B.Sc.

Full particulars of the School may be obtained from Miss Margaret Tatton, Secretary, Civic Education League, Leplay House, 65, Belgrave Road, Westminster, S.W. 1.

Dr. P. Seymour-Price will give a lecture on "Some Points about General Practice," in the Clinical Theatre at 12.0 noon, on Tuesday, June 7th.

Dr. H. M. Stewart will give a lecture on "Case Records in General Practice," in the Clinical Theatre at 12.0 noon, on Tuesday, June 21st.

Specialities.

Messrs. KODAK, Limited, Kingsway, W.C. 2.

The Eastman Dupli-Tized X-Ray Film is the result of exhaustive experimental work in the X-Ray Department of the Research Laboratory of the Company.

The wide appreciation which this Film has received, and the extent to which it has been adopted in X-ray photographic work must be most gratifying to the originators.

They claim for this Film greatly increased efficiency. It is Dupli-Tized—that is, the sensitized emulsion is coated on both sides of the transparent base, with the object of obtaining increased speed, and simplifying and shortening the process of developing and fixing.

The Dupli-Tized X-Ray Film needs no comment. . . . The fact that this film is in use at this Hospital, at St. Bartholomew's, St. Thomas's, and at the majority of the largest hospitals in the United Kingdom, is in itself, the best guarantee of its worth and merit.

The Kodak Company will always be pleased to afford every facility to those interested, for explanation and demonstration, either at the above address, or anywhere where X-ray work is done.

"MAXALDING," 67/69, Chancery Lane, W.C. 2.

For toning up the nervous system, and keeping the body fit, Mr. M. Saldo has, after a careful study of the subject, devised a course of exercises which anyone may take with advantage.

These exercises consist chiefly of a combination of movements so arranged, as to prevent any repetition of the same movement.

By the Maxalding System, the muscles are contracted, stretched, and relaxed in organised sequence, and are thus developed to a surprising extent.

Photographs of Mr. M. Saldo's pupils are excellent evidence of his system.

For persons suffering from constipation, neurasthenia, and kindred complaints, these exercises are of acknowledged value.

Mr. Saldo has given demonstrations of his sytem with great success, and will be glad to furnish anyone with particulars of these exercises on application, by letter, or interview at the above address.

The Retinoscope.

This simplified ophthalmoscope has been devised for the routine examination of the optic disc in which no accurate measurements are required. The retinoscope is not equipped (as the diagram shows) with the array of lenses which make the ophthalmoscope so expensive. In consequence it is not possible to use it for the measurement of refractions nor for such investigations as the estimation of the degree of papillœdema, but for the ordinary examination necessary in the medical wards it is quite efficient. Here all one wishes or hopes to detect usually, is the presence or absence of such more or less obvious conditions as retinitis of optic atrophy. The instrument can be used on all normal or myopic eyes, but fails with some hypermetropic eyes. However, this is no great disadvantage, as the latter form but a small fraction of those which one is called upon to examine.

Tooth-Extraction.

THE following is an extract from a chapter on tooth-extraction in the work on "Dental Pathology and Surgery," by S. James A. Salter, M.B., F.R.S. Dental Surgeon to Guy's. The book was published in 1874, and in the chapter in question, Salter discusses "the accidental extraction of a wrong tooth." He says:—

"The first (the slipping of the instrument after application and before traction) is essentially the accident of the student; and how often have I seen a nervous young beginner set about the operation as though courting such a result—grasping the tooth with the forceps and then, turning away his head with an eager, anxious face, commence tugging lustily without ever again assuring himself that he still pulled at the tooth he had chosen. The early example to this disaster to which I have referred occurred in the first days of my pupilage, when I was articled to a general practitioner in the country. One of my fellow pupils, somewhat older than myself, was a reputed expert at tooth-drawing, and great was the execution which he did with a certain rough dexterity, among the decayed teeth of the poorer people of the parish, and great was the reputation he was gaining, till one day a disaster occurred and his character collapsed very suddenly. Mr. K. took out teeth boldly and without hesitation; but then he had the student's trick—he applied the instrument and everted his head, and his glance only returned when the proceeding was completed. I well recollect the calamitous morning when a neighbouring linen-draper's assistant came to the surgery with a swollen face and a dreadfully inflamed gum to have his decayed and aching right lower first molar 'drawn.' He was seated in the special chair; the key (Mr. K.'s favourite instrument) was duly clothed with lint and the operation commenced. The claw was applied to the tooth and my friend everted his gaze.

Presently something gave way; the instrument started from the patient's mouth and a tooth rolled on the floor. But it was not the carious molar. There upon the carpet lay the second bicuspid—sound, white and spotless; while the cause of all the patient's suffering was just where it had been before. The poor man left the surgery much worse off than when he came—his tooth-ache was terribly exasperated, his tender gum bruised and lacerated by the fulcrum of the key, and his jaw minus a sound tooth.

There was a great disturbance; legal proceedings and damages were talked about; but unexpected circumstances put an end to the matter. About a week after the catastrophe the patient had violent

hæmoptysis, and a few days after he died in a second attack. But the lesson I learnt that morning has never been lost upon me and many a Guy's student has had the benefit of it for I lay it down as a canon law in my first precepts on tooth-extraction—'When you have applied your instrument to the tooth keep your eyes on both till the tooth is in your hand.'"

The Architectural Association Journal.

The Editor of the *Architectural Association Journal* has kindly arranged to exchange his instructive and influential journal with the GAZETTE. The interests of the two papers, and of the two communities which they serve, overlap on many points, such as house construction and public health. Any of our readers that may wish to read this interesting journal, whose pages are replete with well written articles upon the varied aspects of the science and art of architecture, will find copies in the Wills Library.

Papers by Guy's Men.

F. J. Steward, M.S., F.R.C.S. A Clinical Lecture on Acute Infective Arthritis.—*B.M.J.*, May 21st, 1921, p. 727.

Philip Turner, M.S., F.R.C.S. Obstruction by a Band in a large Scrotal Hernia.—*Ibid.*, p. 738.

Hildred Carlill, M.A., M.D. Manifestations of Hysteria.—*Lancet*, May 21st, 1921, p. 1074.

T. G. D. Bonar, M.B., B.S., M.R.C.S. Two Cases of Retroperitoneal Hæmorrhage. —*Ibid.*, p. 1078.

Change of Address.

C. Warner, Moira, Royal Esplanade, Margate.

Arthur Thomas, Surgeon Commander, R.N., H.M.S. *Sandhurst*, c/o G.P.O., London.

The Photograph of Clinical Wards.

Re "Guy's Gazette" Clinical Wards.

Miss Strick's View.

The men standing in the entrance are :—

R. O. Moon.
J. Howell.
P. R. Lowe.
A. H. Spicer.

I believe I can identify four old "Clinical Groups," and the photo was taken 1895. They were not all on the same batch of "Clinicals." I thought the identification might be of interest.

ASTLEY V. CLARKE.

Leicester,
15th May, 1921.

Reviews.

Radiographic Technique. By T. Thorne Baker, A.M.I.E.E. (Messrs. Constable & Co.) Pp 196. Price 15s.

The author has in this book given an account of the technique of X-ray photography.

In the first chapter the actual X-ray plant is only described in sufficient detail to make the useful notes on localising the site of a breakdown clear.

The second chapter deals with the photographic plate. Here we are presented with a clear account of the differences between an ordinary plate and an X-ray one. Methods of testing the usefulness of plates for radiographic work are given, and several types of radiometers for measuring the hardness of a tube are also described. The disadvantage of having the objects too near the tube is shown by two radiographs of wire gauze taken at different distances. Due instruction as to exposure is given—the varying factors, hardness, distance from tube, the number of milliamperes passing through the tube, and the density of the object—are combined in a useful but short table.

The treatment of plates the rationale of development and various formulæ occupy the next chapter, which is concluded with a description of the common faults found in negatives and their usual cause.

Intensifier screens have a chapter to themselves, stress being laid on the necessity for very close contact between screen and film and for absence of dust; the question of special plates and developers is also dwelt on.

Chapter five deals with the fluoroscopic screen. The various substances which can be used and their relative advantages are discussed. Protection of the worker also is touched on here. A short chapter follows giving methods of localisation and stereoscopy. The next three chapters deal with the dark-room and its equipment, intensification and reduction of negatives, and printing in all its varieties.

Chapter ten gives some very interesting examples of the application of X-rays to industrial problems. Thus, faulty welds, flaws in metal, rubber tyres, and golf balls can be detected nowadays, and even, as is shown in the next chapter, chemical analysis can be attempted.

The author is to be congratulated on producing a book, bristling with technical details, and yet so easy to read and follow. The illustrations are very good. The book is certainly one to recommend to all interested in radiography.

Aids to Chemistry. By William Partridge, F.I.C. (Messrs. Balliière, Tindall and Cox.) Price 6s. net.

This volume is one of the Students' Aids Series; it has been entirely rewritten by the author, who is well known as a contributor to other volumes of this Series.

In this book we find an enormous amount of information condensed into 268 small pages; general chemistry, inorganic and organic chemistry are all here in abstract.

Candidates for examinations in chemistry will find this a very useful book.

It would be very easy to find fault with the book, where so vast an amount of subject matter is condensed it is no doubt impossible for any author to give more than a glimpse of many of the newer methods and discoveries. We note, however, that in the periodic table on p. 28 the gases of the Helium Argon group are omitted, although these gases are referred to later, p. 70. Radioactive emanations are alluded to but there is no mention of radio-activity.

A number of the metallurgical and manufacturing processes which are described are now obsolete, for example, the Leblanc process; as many of these are of historical interest we suppose the unfortunate student will still have to memorise them.

Skin Diseases in General Practice. Haldin Davis, M.B., B.Ch., M.A.Oxon., F.R.C.S.Eng., M.R.C.P. 2nd Edition. (Oxford Medical Publications.) 1921. 25s. net.

One is accustomed to find that a book on dermatology is a huge volume arranged on some complex and often unjustifiable ætiological classification; it is usually a book of great use and of great interest to the skilled dermatologist, but of very little value to the average student or general practitioner. For if he comes across an unfamiliar rash, the average man cannot even hazard a guess at its ætiology, and so he has to search through chapter after chapter on the lookout for some description or illustration with which the rash which is puzzling him corresponds.

Dr. Haldin Davis, has written a small book on dermatology which has solved the practitioner's difficulty. He has excluded from this book all those rarer maladies which, cropping out every few years serve only as an excuse for further learned papers before dermatological societies. The commoner diseases which are left he has arranged in a topographical classification so that the practitioner confronted with an unknown rash on the face or on the limbs has merely to consult the appropriate chapter and he will find not only a list of diseases which may show themselves on that part of the body, but also a well written differential diagnosis which will help him to decide with which of these lesions he has to deal. Having thus been able to diagnose the condition which confronts him, he will also find epitomised here the appropriate treatment.

In this new (second) edition, the text has been revised and new work has been added on the treatment of syphilis and of ringworm of the scalp. New illustrations, both photographs and coloured plates, have been added, but there are still too few coloured plates. As is the fault with most skin text books too much reliance is placed on photographs, which, at the best, give but an incomplete idea of the appearance of a lesion. The ideal book on dermatology would have as illustrations only stereoscopic colour-photographs.

The Diagnosis and Treatment of Peripheral Nerve Injuries. (Medical Research Council.)

No subject has stood in greater need of discriminative investigation and condensation than that chosen for this work. It is, therefore, particularly gratifying to find that the contained information is not only a concise review of modern surgical thought, but also forms an invaluable practical guide to those confronted with the manifold problems of nerve injury.

Methods of examination of the extent and localisation of neural lesions and their appropriate treatment are dealt with first generally and then with reference to individual nerve trunks. Much stress is laid on the importance of recognising "Trick" movements in the simulation of return of function, many interesting examples of this being given.

The illustrations and section on causalgia are also worthy of comment. The book will be a great aid to surgeons and senior students.

The Heart: Old and New Views. By H. L. Flint, M.D. (Messrs. H. K. Lewis, London.) Price 15s. net.

Dr. Flint has succeeded in writing a most attractive and readable little volume, which should be of great interest to all those whose work, or interest, lies in the elucidation of the many problems presented by the heart.

The first part of the book deals with the development of our knowledge about the heart, from ancient times to the discovery of the circulation by Harvey.

The second part deals with the evolution of instrumental methods.

The book is well illustrated with diagrams and reproductions of electrocardiograms. The treatment of cardiac conditions is only lightly touched upon, since this is a historical study and not a clinical manual. But it is not merely as the work of a his-

torian that we should consider this book. Dr. Flint has had considerable experience of the practical side of his subject, so that his work is that of an expert. He who would appreciate modern science must study the steps whereby it was built up, before he can fully realise its true value. In this lies the interest of Dr. Flint's work.

Guy's Hospital Reports (No. 2, Vol. 1, Fourth Series), April, 1921. Price 12s. 6d. net, or £2 2s. per volume of 4 numbers.

This second volume of the new edition of the *Reports* contains too many well written articles for me to praise each individually as it deserves in this short review. There is no article here that does not reflect careful thought and meticulous investigation. It must suffice for me to present short comments upon what seem to be the most valuable articles in a very valuable series.

Firstly, Dr. Nicholson in a most readable article discusses the problems of tumour formation and denies the common belief that tumours do not serve a purpose useful to the organism. He shows, by citing several interesting cases, how tumours have been found to retain the function of the organ from which they grow. He would have us regard tumours merely as one variety of malformations.

Mr. Ormond contributes a very useful article on the effects of violet and ultra-violet rays upon the eye.

Dr. Hurst and Mr. Rowlands have collaborated in a paper which gives the medical and the surgical aspects of hour-glass contraction of the stomach, while Dr. Ryle records a number of experiments on gastric secretion which he performed on himself.

Sir William Hale White completes his contribution upon Bright's life and work, and Dr. Newton Pitt has written a short biographical sketch in memoriam to Dr. Pye-Smith, who died in May, 1914.

There are also three articles from the Throat and Ear Department, contributed respectively by Mr. Mollison, Mr. Layton and Mr. Zamora, while Mr. Rowlands' case of an impacted upper wisdom tooth is commented upon by Mr. Hopson.

Thus we have here a very valuable number of the *Reports*, which has fully maintained the high standard the first number set. Judging by the titles of the aricles which Dr. Hurst promises us in forthcoming numbers, the *Reports* will long continue to be as good.

A Manual of Surgical Anatomy. By Charles R. Whittaker, F.R.C.S.Edin., F.R.S.E. Third Edition. (Messrs. E. and G. Livingstone, 1921.) Price 15s. net.

This book should be a very popular one. It is well written, well printed, and is supplied with a number of very clear and very helpful diagrams, and in this third edition a number of normal X-ray photographs has been added. These are very welcome, for when one begins to study X-ray plates, one is usually handicapped by not having been able to study previously the normal X-ray appearance of the various bones. In consequence one is tempted to regard normal epiphyseal lines as fractures, and to be deceived by the differences in shadow cast by overlapping bones.

In view of the advances which have been made in the last few years in chest-surgery the clearly written chapter on the surgical anatomy of the thorax is also very valuable, though perhaps in later editions it will have to be enlarged to keep pace with the advance of knowledge. One has no hesitation in recommending the book to all who require a concise book from which to revise their anatomy from the surgical view point.

University of London Sports.

Last year Guy's tied with King's College for the honour of holding the Rosebery Shield. Unfortunately the University of London Sports come rather early in the term to allow of much serious training, and the training facilities which one expects at an institution such as ours are not at hand. The Sports Committee share the constant complaints of the Tennis and Cricket Committees, either the ground is unmarked, unwatered, or not kept in a state which would warrant the £5 5s. yearly subscription for members. After several pleadings for the hurdles to be brought out from their hibernating quarters, they put in an appearance ten days before the sports. Even now no running track has been marked out, and there are no signs of a long jumping pit, and there are no cross bars for the high jump.

Mr. L. G. Housden, despite the time demanded for the primary fellowship, has been a most enthusiastic secretary. He collected quite a good team and encouraged them both by precept and example to do a certain amount of training. This is a task of some magnitude. Yet this man of many parts has been unable to cope with the condition of our ground. Surely with Harris and his assistants and their up-to-date apparatus our ground should be in a state of perfection, and all the necessary "impedimenta" for sports and games always ready.

University College won the "Rosebery" with 37 points, Guy's being second with 32. For the winners Banks performed brilliantly, setting up a record for the hurdles, clearing 5ft. 4½in. in the high jump, and getting second place in the long. One also admired the running of both Lightwood and Ashford of King's.

For Guy's, Steyn, despite rumours of a strained thigh, ran with great strength. He equalled the record for the 100 yds. and was but 1-5sec. outside the 220 yds. record. It is a pity he could not be persuaded to run the 440 yds. in the relay race. Had he done so we should probably have been in a much stronger position. Baugh is disappointing; for 80 yds. he runs excellently, but can finish neither the 100 nor 220 in proper style. His selection to run the 440 yds. in the relay race was absurd, as the distance is much beyond him. Roberts jumped in nice style. Albertijn hurdles well and with training will have to be reckoned with in the Inter-Hospital Sports. Gough in the half-mile ran with lots of heart, and should improve much. Greenway did well in the first heat of the 440, but was not in good enough condition to last out the final. Our entrants for the mile were outclassed, but one liked the spirit with which they ran. In the three miles Housden gave one the impression of not being in perfect condition, and was beaten by a man who ran an excellently judged race. Chambers ran cleverly, pacing his first string

in very unselfish style. The tug-of-war team—Zondagh, Biddle, Maree, Harvey, Neser, Taylor, Rowbottom, and Hutchisson—coached, shouted at, implored, and abused in turn by the ever popular and keen "George" Doherty, justified both their appearance and selection. Notwithstanding "George's" display of unexpected knowledge of a Maori war dance, we were greatly impressed by the King's coach—why didn't they go the whole hog and engage George Robey for the occasion? No opposition to speak of was encountered by the tug-of-war team, and they pulled their way undefeated through East London College, King's, and Goldsmith's College. The pull against King's was the hardest.

H.R.H. Princess Mary honoured the meeting with her presence, and afterwards distributed the prizes.

Throwing the Hammer.—R. Rostron Crossley (University), 81 ft., 1; C. A. Risbridger (King's), 2.

100 *Yards.*—C. L. Steyn (Guy's), 1; H. S. L. Dyer (E.L.C.), 2; E. J. Church (Birkbeck), 3. Time, 10 2-5 sec.

High Jump.—J. R. Banks (University), 5ft. 4½in., 1; J. D. P. Roberts (Guy's), and A. H. Barker (Birkbeck), tied at 5ft. 3½in.

One Mile.—R. C. Lightwood (King's College Hospital), 1; W. H. Ashworth (King's College), 2; C. W. Reid (L.S.E.), 3. Won by 50 yards. Time, 4 min. 33 2-5 sec.

120 *Yards Hurdles.*—J. R. Banks (University), 1; P. Albertijn (Guy's), 2; H. C. Raynor (King's College Hospital), 3. Time, 17 1-5 sec.

Putting the Weight.—J. McOustra (University), 32 ft. 5 in., 1; H. Astley Cooper (King's), 2; R. Rostron Crossley (University), 3.

220 *Yards.*—C. L. Steyn (Guy's), 1; L. R. Marsh (King's), 2; E. J. Church (Birkbeck), 3. Time, 22 1-5 sec.

Half-Mile.—C. W. Reid (L.S.E.), 1; A. S. Gough (Guy's), 2; A. L. Rowney (University), 3. Won by 10 yards. Time, 2min. 57 1-5sec.

Quarter-Mile.—H. L. S. Dyer (E.L.C.), and C. W. Reid (L.S.E.), a dead-heat for first place; E. J. Church (Birkbeck), 3. Time, 53 4-5 sec.

Long Jump.—N. L. Sylvester (King's), 19ft. 6in., 1; J. A. Banks (University), 18ft. 7in., 2; C. Maddy (E.L.C.), 18ft., 3.

Three Miles.—W. H. Ashworth (King's), 1; L. G. Housden (Guy's), 2; W. Larkins (Goldsmiths), 3; Housden was in front a lap from home, but Ashworth spurted strongly, and won in 15 min. 54 4-5 sec.

One Mile Relay.—King's College Hospital, 1; University College, 2; King's College, 3. Won by 30 yards. Time, 3 min. 52 3-5 sec.

Tug-of-War.—Guy's Hospital beat Goldsmiths by 2 pulls to 0.

Guy's Hospital Rifle Association.

The following have been elected office bearers for this season:—

President and Vice-Presidents as last year.

Captain—Mr. G. W. Elkington.

Secretary and Treasurer—Mr. G. Beamish.

Committee—Messrs. W. H. Foy, H. O. Eksteen, G. A. Lloyd, G. V. Bingay, M. C. Hart.

There was a General Meeting held on April 29th. Mr. Thompson presided, and a fair number were present. Targets have been obtained at Bisley and are available on Wednesdays and Saturdays.

Meetings are held every Wednesday. The Hospital has eight rifles in use and it is hoped to add a third to the two actually belonging to the Hospital.

Ammunition is being supplied by the Association. It is hoped to hold the Hospital Competitions during the last weeks in June, and the Inter-Hospital Competition during July.

Railway fares to Brookwood at a considerably reduced rate are obtainable on production of a voucher procurable from the Secretary.

Mr. G. E. Foulton, a former King's Prize winner, has kindly consented to continue to act as our Armourer. The Association is affiliated to the National Rifle Association, also to the United Hospital Rifle Club, and to the London and Middlesex Rifle Club, who have a hut at Bisley where meals can be had.

It is intended to continue the Spoon shoots at 200, 500, and 600 yards, which were so successful last year. The President has very kindly offered a prize to the shot who makes the best average at 200 yards during the season.

Last year the season proved a great success and if we are to maintain our laurels and make this season an even greater success we must have your combined support, and I appeal to everyone to make an effort of attending as many meetings at Bisley as he possibly can.

Pavy Gymnasium.

The Annual General Meeting of the Pavy Gymnasium will be held on Thursday, June 2nd, 1921, at 1 p.m., in Class Room I. Agenda :—

1. Balance Sheet.
2. Election of Officers.
3. Annual Report.
4. Any other Business.

All students who are interested in Boxing, Fencing, Gymnastics, or allied sports, are invited to attend. Advantage should be taken of this invitation by all new men who wish to know something of the activities of the Pavy Gymnasium.

Births.

CURLE.—On May 14th, 1921, in London, to Margaret and Cyril Curle, the gift of a daughter.

MACHIN.—On May 7th, at "Villa Capri," Longlevens, Gloucester to Corinne the wife of L. Machin, L.D.S., a son.

SCOTT.—On April 9th, 1921, at Botacamund, Nilgeri Hills, South India, the wife of Capt. D. C. Scott, O.B.E., R.A.M.C., a daughter.

Marriage.

McALPIN—JAMES.—On Saturday, April 16th, 1921, at the Presbyterian Church, Putney, Kenneth Fergus McAlpin, only son of Mr. and Mrs. McAlpin, 47, Hagelwell Road, Putney, to Gwendoline Winifred, daughter of the late Dr. James and Mrs. James, of 16, Colmette Road, Putney.

ED.—A. T. R.

GUY'S HOSPITAL GAZETTE.

VOL. XXXV., No. 859.] JUNE 11, 1921. [NINEPENCE.

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Passim.

THE report of the Voluntary Hospitals Committee, presided over by Lord Cave, was issued on Thursday. The Committee state in no uncertain terms their belief in the voluntary system, and do not uphold the idea of State support. Nevertheless they recognise that an emergency exists and that grants are necessary to tide this over. It is recommended that immediate relief be given in special cases.

The Committee recommend the formation of a Voluntary Hospitals Committee for each County or County Borough, the King Edward's Hospital Fund to act for London. The Ministry of Health should be asked to form a Hospital's Commission to deal with these committees and to allot grants upon their recommendation. It is suggested that Parliament be asked to sanction a temporary grant of £1,000,000 for 1921,

The present unfortunate condition of hospital finances can hardly be attributed to lack of public support. The enormously increased cost of maintenance due to the war has had more to do with the question. Be that as it may, the existent state of affairs has led some pessimists to the conclusion that the voluntary principle must be abandoned. The Cave Committee do not agree with this. They consider that temporary relief is necessary, but that the voluntary system is worth saving, and can be saved.

But if this is to be effected, measures must be taken to re-establish the self-supporting position of hospitals. The Committee draw attention to such steps as review of expenditure, co-operative buying of drugs, apparatus and stores, and further development of new sources of income, such as subscriptions from wage-earners and employers, and contributions from approved societies. Many of these measures have already been adopted at Guy's.

The days are past when it was possible to rely entirely upon large donations or legacies —at all times a precarious source of income— and some more constant means of obtaining the requisite funds must be found.

Mr. Leonard Keyser's proposals in the *Times* suggest a scheme which London Hospitals might well follow. He outlines the plan in force at the Royal Hampshire County Hospital.

At this institution the patients are required to contribute to their maintenance, with the exception of (1) the necessitous poor, and (2) those who insure themselves for free treatment.

The insurance is effected by payment of 2d. a week for each adult and 1d. for a child, or 6d. for a family.

In effect, the hospital authorities say to their patients, "You keep us while you are well, and we will look after you when you are ill."

This insurance method would provide not only free In-Patient treatment, but insured persons would be entitled to Out-Patient treatment and the benefit of such additional investigations as those of the X-ray Departments. General practitioners would be able to send insured patients up for free investigation, and there would be no appearance of charity about the proceeding, as the patient would feel that he was doing his share in the support of the hospital.

As Mr. Keyser points out, 2d. a week from every wage earner in London would amount to a considerable sum, which would be of distinct use in providing that steady source of income which is so badly needed.

Mr. Keyser fears that the organisation of the scheme would present undue difficulty, but it should be practicable, as much so as any other general insurance.

This plan has been advocated by *The Hospital* for some time, and it is evident that some such scheme presents a possible solution to the present difficulties. Government subsidies to especially poor hospitals are but a temporary measure. Something permanent must be evolved.

THE War Memorial is nearing completion and the Prince of Wales will perform the unveiling ceremony on July 15th. Naturally many old Guy's men and nurses will wish to be present, and relatives of the fallen will, of course, be invited. The arrangements are as yet incomplete, but we understand that the function will be of a more or less private nature.

Much discussion and controversy have taken place, both about the form the Memorial should take and about the nature of the inscription. But we feel that the many suggestions have at last given rise to a Memorial which will be a fitting tribute to those who gave their lives.

THOSE of us who have lived at any time at Honor Oak Park are sure to have experienced a long wait in the train at one time or another in the neighbourhood of "Vinegar Junction." One of the most edifying occupations during such a stoppage is to examine the various advertisements placed along the line. Perhaps the most conspicuous of these is a huge placard bearing the legend, "Stop Vivisection—a Disgrace to England." There it stands, a monument to the enthusiasm of those who caused it to be erected, and a source of edification to the Guy's men continually passing up and down the line.

Of all occupations, that of going about telling people how extremely wicked somebody else is seems to have the greatest number of followers. Whatever a man does, somebody is sure to rise up in wrath and hurl expletives at him. To some people mixed bathing is anathema. Others dislike mixed tennis. But the patient investigator who spends years of his life in attempting to elucidate the mysteries of disease seems to come in for more invective than anyone.

But would an anti-vivisectionist be so true to his principles as to refuse to avail himself of treatment, the technique of which is based upon a study of processes in animals? We doubt it.

Fortunately not all people are so carried away by their enthusiasms. We notice that the second reading of the Dogs Protection Bill, which prohibits vivisection experiments upon dogs, has been rejected.

We are pleased to see that Sir Watson Cheyne put in a good word for the medical profession,

and pointed out that while he thought his friends of the scientific and medical professions were dog lovers, they "could not afford to lose the experience that might be gained from these experiments." We congratulate the House of Commons upon the sense of its members.

The Borough was be-flagged in anticipation of their Majesties' visit on the occasion of the opening of the new Southwark Bridge on Monday. Lovers of Dickens will regret this breaking of yet another link with "Little Dorrit" and her companions in literature, but personally we welcome the advent of any means whereby the congestion, so usual nowadays upon London Bridge (aggravated by the existence of a hole in the road upon which patient artisans have beeen labouring), may be relieved. It is to be hoped that the vernal hue of the new bridge will attract passengers, and so leave more room on the great Borough highway.

Why is it that it is so difficult to persuade people to leave periodicals in the College Reading Room? We are continually reading notices threatening the withdrawal of certain magazines unless men cease from appropriating them to their own uses. But apparently these warnings are without effect.

It has been brought to our notice that the covers belonging to *Blackwood's Magazine* and *The Practitioner* have been removed. As a result of this, these periodicals are not to be found. Thus the selfishness or carelessness of a few persons causes inconvenience to many. Surely in a hospital such as ours, a Reading Room should not be subject to these predatory onslaughts.

We publish on page 227 a letter from the Secretaries of the Athletic Club drawing attention to the two big athletic events which are to take place during the month.

The Guy's Sports are being held at Honor Oak Park next Wednesday, and the Inter-Hospital Athletic Competition will be held at the Queen's Club on the 28th instant. It is hoped that Guy's men will roll up in force and make both events successful.

We have lost the Rosebery Cup at the University of London Sports, and we should now make every effort to prevent the Inter-Hospital Athletic Shield from being wrested from us. We would especially urge that all men who possibly can, do their best to be present at Queen's Club to cheer our team to victory.

Another Inter-Hospital contest is the Swimming and Water Polo Competition which will take place at the Bath Club on July 1st at 8 p.m. In addition to the swimming, diving, and polo contests there will be an exhibition of diving by members of the A.D.A. Tickets may be obtained from the Secretary of the Guy's Swimming Club, and those who wish to enter for any of the handicap events may pay their entry fees to him.

We offer our sincere congratulations to Mr. J. A. Snarey Wright, who has obtained the Higher Dental Diploma of the Royal College of Surgeons of Edinburgh, at the Examination held in May, 1921.

We welcome the promised reappearance of our cheerful little contemporary. Its frequent lapses into silence and spasmodic bursts of energy make it all the more sought after when it does arrive. We who are doomed to the utterance of weighty diatribes, and sometimes, perhaps, a certain amount of solemn warning in these columns—"flashes of genius from the Editorial chair," as one cynic remarks—gaze occasionally with outstretched necks and longing eyes at the chances of being flippant which the *Guyoscope* presents.

J. A. C.

"FITS."

CLINICAL LECTURE BY DR. C. P. SYMONDS.

GENTLEMEN,—I do not propose to discuss all the various causes of fits. The enumeration would occupy most of my time, and the facts may be obtained by you from any text book. They are tabulated most clearly, I think, in Sir James Purves Stewart's book entitled "The Diagnosis of Nervous Diseases," wherein you will find a chapter devoted to the subject. It has the advantage of being brief and easy to read.

In this lecture it is my purpose to illustrate a few points of importance from the pages of my clinical note books. Before proceeding to this task, however, I will draw your attention to one or two fundamental points in the pathology of fits.

The term "fit" in lay phraseology covers a multitude of diverse conditions, from a fit of coughing to a fit of the blues. In the widest sense in which it is used in our profession it implies a temporary disturbance of the functions of the brain. We can divide fits roughly into two categories according to the functional level at which the disturbance occurs—physiological or psychological. In the former group the disturbance of balance is caused by damage to the structural mechanism of the brain, in the latter some disarrangement of the emotional forces which play upon the brain. One may, perhaps, draw an analogy from the internal combustion engine. The disturbance of function known as misfiring may be due to an actual lesion in the engine—such as a broken inlet valve—or to an improper adjustment of the mixture of petrol and air. The broken valve may be compared with the disturbance at the physiological level—it is an organic lesion as we use the term in medicine. The wrong mixture may be likened to disturbance at the psychological level and may be regarded as the equivalent of a functional disorder.

Perhaps I should do well to explain exactly the sense in which I am now using the terms organic and functional. By an organic condition I mean one in which we have reason to believe that there is some definite damage of a particular organ—in this case the brain—even though we are unable to demonstrate the lesion post-mortem. By functional I mean a condition in which the disability is due not to a lesion of any particular organ, but to a failure of the personal unit as a whole to adapt itself to its environment. There is one point which is of outstanding importance in the differentiation of organic from functional fits. It is this, that in functional fits in which the structure of the brain itself is undamaged there is never *complete* loss of consciousness. The converse of this, however, does not hold; that is to say, consciousness is by no means always lost in fits of organic origin. A further point is that in the case of organic fits we frequently find evidence of lfocalised disturbance of brain function, which of course does not occur and would not be expected to occur in the case of a functional condition.

Fortunately we are possessed of a good deal of knowledge as to the localisation of function in the brain. We know that the cortex of the pre-Rolandic area has to do with voluntary movements, the post-Rolandic with sensation, the occipital lobe with vision, the uncinate gyrus with smell and taste, and part of the temporal lobe with hearing. We are enabled by the use of this knowledge to discover in many cases of fits not only that the condition is an organic one, but that the lesion is situated within fairly definite limits.

The first case which I have to record will illustrate some of the points of which I have spoken :—

W. S., aged 51, an electrician, came to hospital complaining of fits. He had had typhoid and malaria when about 25 years of age; no other serious illnesses. He put his present trouble down to the fact that he had a very severe electric shock 8 years ago, receiving a current of 18,000 volts on the left side of his head. He was not unconscious after this, but ever since then has felt nervous—would get "worked up" over his occupation, and would start if he heard anything behind him. Two years ago he had his first fit. He was supervising the work of a gang who were digging a cable trench in a cellar, when he suddenly felt dizzy, had a pain in his forehead, and began to have curious visual disturbances as if he were looking through first blue and then green spectacles, and then through smoked glass. He then had in his own words, "a smelling sensation up through his nose like sewer gas." He did not lose consciousness. The whole at-

tack lasted only two minutes and he went on with his work.

After that he continued to have attacks of a similar nature every three or four weeks. The incidents always occurred in the same order, first pain in the forehead, then colour disturbance, then the unpleasant smell. The attacks did not prevent him from working, and he was able to operate a crane during an attack. One year after the onset he had an attack ending in loss of consciousness. Subsequently he continued to have minor attacks as before with occasionally a major attack. The longest interval in which he was free from fits was two months. He spontaneously remarked that they seemed to come on when he was worked up or excited.

In reply to leading questions he stated that vision had been failing in his right eye for some months, and that he had lately suffered almost every day from headaches which were referred to both sides of the forehead. He had also noticed that there had been progressive loss of sexual desire since the onset of his fits.

On examination he proved to be a heavy, well-built man, rather nervous and excitable, depressed over his fits, but with no obvious sign of organic disease. The Wassermann reaction was negative in the blood. The positive signs on neurological examination were :—

1. A large central scotoma in the right visual field.

2. Definite pallor of the temporal edge of the right optic disc.

3. Very slight weakness of the left side of the face and tongue.

Now the point of great importance in the history of this man is the unpleasant sensation of smell which was a constant occurrence in his fits. This symptom was first described by Dr. Hughlings Jackson as an accompaniment of lesions of the uncinate gyrus of the tip of the temporal lobe on either side. This point alone in the history, therefore, made one immediately suspicious of a localised lesion of one or other temporal lobe.

The commencing atrophy of the right disc and the central scotoma on that side pointed to a lesion of the optic nerve in front of the chiasma, the weakness of the opposite face and tongue would suit with a lesion of the right crus cerebri. The loss of sexual desire could best be explained by a lesion of the pituitary body.

Fitting these points together one concluded that there must be a lesion in the angle between the tip of the right temporal lobe, the pituitary body, and the right optic nerve.

The X-ray plates showed a calcareous mass about twice the size of the sella turcica which lay in front of the anterior clinoid processes as seen laterally, and about one inch to the right of the middle line as seen in the antero-posterior view.

Operation revealed an encapsuled tumour, the size of a golf-ball, growing from the posterior border of the greater wing of the sphenoid on the right side. The stalk by which it grew was calcified. This was completely removed by the surgeon, Mr. W. E. Dandy. Unfortunately the patient died later from hæmorrhage and shock.

From this case we learn :—

1. That fits with or without loss of consciousness may be for a long time the only sign of a cerebral tumour ; and

2. That a cerebral tumour may grow to a very considerable size without giving rise to severe headache, vomiting or papilloedema.

The next story I have to tell you is that of a labourer, W. W., aged 50, who came up to Guy's last month on account of some trouble with his speech.

The history showed that he was quite well up till July, 1920, when one day as he was getting some sacks to put on his wagon he felt the right side of his face twitching; after a minute or two the twitching spread to his arm and he then lost consciousness. He came to in a few minutes finding his right arm a little numb and weak, but went on with his work. After that about once a week he would get an attack of twitching of the right face, especially of the orbicularis oris; occasionally the attack would affect the arm a little; he would sit down and the whole affair would last about three minutes; he never again lost consciousness.

After Christmas he noticed that his speech was affected in that he had difficulty in forming his words, and this had lately become worse. He was sure that his memory and powers of recognition were all right. He had had no headache nor vomiting.

On examination one found that he had a moderate degree of motor aphasia and agraphia; his intellectual faculties were not at all affected. His optic discs showed 2 D of swelling with a certain amount of organisation of the exudate, especially in the right eye. The right side of the face was decidedly weak, especially the lower half. The X-ray plates showed no abnormality. The Wassermann reaction was strongly positive in both blood and cerebro-spinal fluid; the latter showed 5 lymphocytes per cm. and ·02 per cent. protein (normal). In the absence of any signs of increased intracranial tension such as headache and vomiting, one concluded that the swelling of the discs was due to a true optic neuritis—an inflammatory condition of syphilitic origin, and not a papillœdema due to pressure. The fits were ascribed to a localised syphilitic meningitis over the lower part of the left pre-central gyrus. Under anti-syphilitic treatment the swelling of the discs has diminished, the aphasia is less and the fits have ceased.

The point of greatest importance in this case is the existence between the fits of residual impairment of function of a permanent and progressive nature. This always indicates an organic lesion.

A third example of fits with a demonstrable organic basis is the following :—

J. H. T., aged 37, complained to his doctor of numbness of his left leg; there were no clinical signs of organic disease, and the condition was thought to be functional. On enquiry, however, one found that the numbness was not a permanent condition, but manifested itself in attacks of a transient nature. There was first a feeling of pins and needles in the toes which in the course of three or four minutes progressed up the leg, then went to the shoulder and down the arm into the fingers—the left side of the body only being affected. The first attack occurred three months before he came up to Neurological Out-Patients. After each attack his left foot would feel somewhat dead and heavy for a short while. There was never any loss of consciousness.

Clinical examination revealed as the only sign of importance markedly diminished abdominal reflexes on the left side, and some slurring of the speech, which the patient explained as being due to a stutter which he had had since boyhood. The Wassermann reaction was strongly positive in blood and cerebro-spinal fluid, and the latter contained 17 lymphocytes and an excess of protein.

He has had a course of anti-syphilitic treatment, but his condition has not improved, but deteriorated. The speech is distinctly more slurred, the pupils are unequal and react sluggishly to light, so that there can be little doubt but that this is a case of G.P.I.

The fits in this case were presumably due to a localised syphilitic degeneration of the brain cells in the post-Rolandic cortex on the right side.

Sensory fits of this nature are not infrequently ignored by the patient, and even when he comes to the physician their significance may be missed unless one makes a careful analysis of the symptoms.

These three cases of serious organic disease in each of which fits were the symptoms which first attracted notice, will serve to emphasise the importance of investigating such cases with the greatest care and thoroughness.

Case No. 1, the man with the cerebral tumour, had been regarded for two years as one of so-called idiopathic epilepsy, of which condition I am going to speak in a moment. The man with aphasia was thought to be a case of vascular disease. The case, which turned out to be one of G.P.I., was considered to be functional.

The investigations which enabled one to arrive at the accurate diagnosis were :—

1. First and foremost, analysis of the symptoms experienced during the fit. This enabled one to make a definite diagnosis of oragnic disease in each case.

2. Second, the application of the Wassermann reaction to blood and cerebro-spinal fluid.

3. Ophthalmoscopic examination of the eyes.

4. The X-rays.

I must next consider a large class of fits—probably the largest group of all—which I think we ought to consider as belonging to the organic category, as I have defined it, but in which no such obvious signs of organic disease are to be found either in vivo or post-mortem, as in the three cases I have already described. This large class of cases is called idiopathic or genuine epilepsy—so-called simply because we are entirely ignorant of its pathology.

It follows that we are almost equally at a loss for satisfactory methods of treating these patients. We use bromides, prescribe routine diets and routine ways of life, and still the majority of these unfortunates continue to have their fits year in and year out. The problems arising in connection with idiopathic epilepsy are many, and there is no time to deal with them now. The fits probably depend upon no single cause, and it is possible that disturbances at both physiological and psychological levels contribute to their ætiology. In this connection I would refer you back to the fact that one of the patients I have described—the man with the cerebral tumour—not only felt nervous, but that his fits were definitely brought on by emotional stress.

There are some points which may be of value in distinguishing attacks of idiopathic epilepsy from fits depending upon gross organic disease :—

The first is the age incidence: idiopathic epilepsy usually begins in childhood or adolescence. When fits commence later in life one should always be suspicious of other causes, chiefly of cerebral syphilis in some form or another.

Another point is that in idiopathic epilepsy consciousness is nearly always lost, if only for a few moments. A third is that in the case of fits due to idiopathic epilepsy, during the intervals between the fits there are no permanent residues in the nature of alterations in sensation, power or reflexes—except for a few hours after an attack.

I think, however, that we should in the first place be very careful to exclude other possibilities before diagnosing idiopathic epilepsy, and even then we should remember that this is equivalent to "fits of organic nature of unknown origin"—which is a provisional diagnosis only.

The condition for which we ought to be most keenly on the look-out is a latent cerebral tumour, and if we are not going to miss these cases we must make a thorough neurological examination, not only on the first occasion, but at regular intervals subsequently, at least every six months. I can give you from my note books the stories in brief of some cases which illustrate this point.

W. B., a labourer, aged 41, began to have fits at the age of 16, and continued to have them off and on. They always began in the same way—first a headache, then a tingling or numbness of the left foot, as if it had gone to sleep, and then loss of consciousness. He was usually comatose for an hour after the fit, and would have a severe headache. The diagnosis of idiopathic epilepsy was made in his youth, and he was treated with bromides continuously, but without much improvement. At the age of 41—25 years after the first fit—he developed continuous headaches, vomiting, and dimness of vision, for which he came to hospital. Examination revealed marked papillœdema, anæsthesia and some weakness on the left side of the body, chiefly affecting the leg, and an extensor plantar reflex on that side. At operation a small fragment was removed from a very large tumour occupying the right parietal lobe.

This is a remarkably long history for a case of cerebral tumour, but it is not uncommon to discover cases in which symptoms have been present for several years before the occurrence of signs of increased intracranial tension.

F. W., aged 31, had her first fit when 14, her next when 20, and several more prior to coming up to hospital in February, 1921. With each attack she "had a feeling as if a gumboil had burst in her mouth and then a shocking bitter taste," another characteristic example of an uncinate aura, in this case also associated with the typical dreamy state, so that on one occasion she thought she could see her father dressed in a white coat and seeming to be the head doctor of Guy's Hospital; with another fit it was her brother (a British sailor) dressed in the uniform of a French soldier.

On examining her, one could have no doubt that she had a cerebral tumour with severe papillœdema and intense headache. The tumour was unfortunately not found at operation, though her condition has been much relieved by decompression.

Another young girl began to suffer at the age of 15 from attacks of minor epilepsy—transient loss of consciousness from time to time. Her optic discs were examined and found normal, and she was treated with bromides in the usual way. On examining her discs one year later I found intense papillœdema, and Mr. Coburn discovered a right homonymous hemianopia. She had a tumour successfully removed from her left occipital lobe.

I have other cases which illustrate the same point—the need for periodic re-examination of these cases.

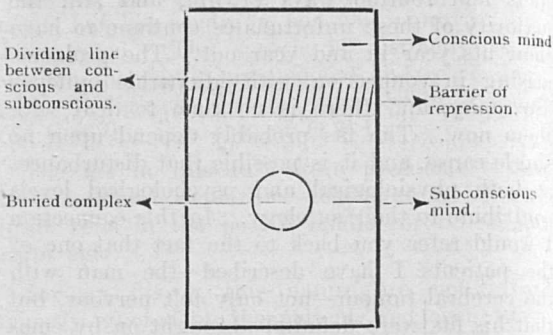
There are, on the other hand, cases of idiopathic epilepsy whose fits begin with signs of localised disturbance of cerebral function, sensory or motor. A case of this type can hardly be distinguished from one of early cerebral tumour, and the differential diagnosis can only be made by watching the patient from time to time.

I have one such case under observation at present—a man of 35 whose fits began seven years ago. They always begin in the same way—he sees lights going round in the right half of the visual field, and with this is sometimes associated twitching of the right arm, after which he loses consciousness. When I first saw him six months ago I noticed that the abdominal reflexes on the right side were diminished. They are now absent, while those on the left side are brisk. I am inclined to believe that he has a tumour of the left occipital lobe, but I do not wish to recommend an exploratory operation until there are further signs.

Before presenting to you in brief the story of my next case—one of fits due to disturbance of function at the psychological level—I must digress for a moment into the realm of normal psychology.

The mental activities and behaviour of man depend upon the potential energy of the emotions. Based upon these driving forces there are organised various trends of ideas and feelings which we may call complexes, and in the course of everyday life there often occurs conflict between complexes based upon different emotions. For instance, a soldier is placed under shell fire. This environmental circumstance arouses two complexes, a loyalty complex, and a fear complex, which are opposed to one another. He makes a conscious choice between the two, and having decided upon following the one course, deliberately suppresses the other. He has thus made a successful solution of an emotional problem. This solution is achieved, however, only at his expense of deliberate and painful effort. For the realisation in consciousness at one and the same time of two opposing complexes is always unpleasant.

For this reason the conscious mind frequently protects itself against such a realisation by a kind of automatic barrier which represses one of the conflicting trends and prevents it from ever coming into consciousness. In this way a whole set of ideas and feelings may be split off and exist below the level of consciousness. Such a condition may be explained diagramatically thus :—



The set of feelings and ideas which I shall refer to as the buried complex is by no means inactive. It has behind it the driving force of emotion, and may be regarded as a hidden impulse which is always striving for satisfaction. Such a buried complex is always producing some effect upon the individual directly or indirectly. He will, for instance, without knowing why, find himself avoiding circumstances which arouse the hidden feelings, he will be especially sensitive to certain topics of conversation, and so on. These are phenomena which we all have opportunity for observing in the psychology of everyday life.

Now if a repressed complex be sufficiently strongly aroused it may break through the barrier into consciousness. The mind, however, still has another mechanism of defence by which it is enabled to prevent a conflict in consciousness of two conflicting trends of ideas. As the one set comes up the other goes down so that the two never meet. The result is that the individual behaves for a time in an extraordinary way; then the position of the complexes is again reversed and he "comes to himself" again without any memory of what has happened.

A further point is this: That portion of the mind whose duty it is to prevent the conscious clashing of complexes—Freud has named this the mental censor—takes the additional precaution of allowing the buried complex to express itself only in such a disguised form that conscious recognition of its purpose is difficult.

Now for my case: The patient, R. B., aged 22, came under my care as a pensioner, and was said to have had epileptic attacks since the age of 12. On going into the history carefully

I was struck by the fact that the attacks were very infrequent—at intervals of some years—and that the patient was of a neurotic disposition, *i.e.*, of the type that has not acquired the power of dealing adequately with emotional problems. On going into the case further I found that each fit had occurred in an emotional setting of such a nature that one might suspect a subconscious motive for the attack. Further analysis established in my mind the certainty that all these fits had been of a functional nature. I have not time to go into these now. I want to describe to you the details of a fit he has had since he has been under my care.

It is necessary first for me to deal with the emotional background at the time. I have time only to put before you the main facts: He was of a very egocentric disposition with hardly any thought except for his own pleasure-seeking; he had been engaged to a girl called A—W—, of his own age, whom he had given up in a fit of pique. He married a year ago a woman five years older than himself. She is now pregnant. While superficially he expressed himself as satisfied, there was abundant evidence to show that underlying this there was a repressed feeling he had made a bad bargain in his marriage, that his additional responsibilities were depriving him of all his bachelor enjoyments and that the coming of a child was going to intensify the trouble. I cannot forbear to mention one of the dreams which helped to throw a light on this buried complex. He dreamed that he was in a shop buying a suit of clothes—which he later identified as his wedding suit—he told the shopman that it did not fit and was rotten stuff and refused to take it. As a matter of fact the actual suit in question which he had worn for his wedding had been a perfect fit. Those of you who know anything of dreams will have no difficulty in interpreting this one.

The circumstances of the fit were as follows: He usually went away for a char-a-banc tour at Easter; this time he was unable to go on account of his wife's condition. He had been feeling "fed-up with himself and everyone else for days." On the morning of the day on which the fit occurred he remarked to his chum at the office that he "felt rotten." The friend told him to take care of himself as he might have a fit, and that would be dangerous for his wife in her present condition. Later in the morning he began to hear faintly a voice calling his name, "Dick, Dick, Dick." He left the office early, went home, had tea, and talked to his wife about himself and his illness; he then took up the paper and began to read a paragraph dealing with divorce proceedings. After this he remembers no more until he found his wife and the landlady standing over him. During the fit he had thrown down the paper, swept all the crockery off the table and then fallen on the floor. He felt better than before the fit and suggested going out for a walk with his wife.

On getting him to associate freely from the voice calling his name, he gave the following: "Girl clerk writing in the office—young woman standing in the door I used to know—A. W. —haven't seen anything of her for a long time —sometimes I think I would like still to be with her—sometimes I don't."

I think the subconscious motives for this fit are fairly obvious, as also the chain of circumstances which aroused them. The fit was the partial and momentary expression of his hidden wish that he might get rid of his wife, or that his wife might have a miscarriage.

His first fit served to save him from a formidable examination, others to get him out of the army, and so on. Fits in his case have come to be a way of escape from the conscious realisation and solution of difficult emotional problems. I am gradually getting him to understand this—one cannot go too fast—and I expect him to be entirely cured.

I could give you other instances of functional fits in which one has been able to find the subconscious motive, but the relation of a single instance in detail is enough.

The main points of value in diagnosing functional fits are the following: First, there is no loss of consciousness, and the patient therefore does not hurt himself by falling; he does not, as a rule, bite his tongue or pass water, though he may do so if he knows something about the nature of organic attacks.

In the second place, the movements which occur are of a purposeful nature, as in the case I have described. Moreover these movements may continue for a considerable time, whereas in true epilepsy or gross organic disease they are over in five or ten minutes.

Thirdly, after a functional attack the patient often feels better for the relief of some of the emotional tension. After an attack of organic

or idiopathic epilepsy the sufferer usually has a severe headache and is dazed for some time.

Moreover, in the case of a functional attack when one knows the emotional circumstances in the life of the individual one can often find a motive for the fit quite easily; as, for instance, in the case of a young lady whom I saw recently who in the course of a prolonged fit moaned frequently "I know he'd come," referring to an absent lover whom she hoped to attract to her bedside by means of an alarming illness.

The lessons which I want you to draw from these cases are that in the case of a patient with fits one should always be at pains first to exclude the presence of demonstrable organic disease, such as cerebral tumour or cerebral syphilis. In cases in which there is no clear evidence as to the organic nature of the fits one should not make the diagnosis of idiopathic epilepsy without careful inquiry for signs pointing to a functional cause, and even when one has made the diagnosis of idiopathic epilepsy one should bear in mind still the possibility of a latent cerebral tumour. Remember that cerebral tumour is a condition which is sometimes curable; functional fits are always curable, while idiopathic epilepsy is relatively intractable.

One of Dr. Lauriston Shaw's principles in diagnosis was, "When in doubt diagnose the condition for which something can be done," and it is often a useful principle to follow.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

DEAR SIR,—I have been asked by a friend, an old St. Thomas' man who was reading the current number of the GAZETTE in my rooms to-day, to say how much he regretted to see the obituary notice of the late Arthur S. Taylor, whom he knew extremely well.

My friend wondered whether you knew that he was an English Rugger International and a Cambridge Blue, and also he thought that Taylor, while at Guy's, captained our Rugger XV. I trust you will pardon me for this letter.—Yours truly,

CHARLES F. PEDLEY.

Winsley Sanatorium,
Near Bath.
May 30th, 1921.

DEAR SIR,—Re Photograph of Clinical Ward, Miss Strick's view, in your issue of May 14th, I think that Dr. Astley V. Clarke's identification in your current number is wrong.

The correct solution, reading from left to right, is, I believe, as follows:—

E. Bellingham-Smith,
H. S. Knight,
E. M. Harrison,
G. Hamilton.

They all belong to the same batch of Clinicals and with E. C. Lowe and A. V. Maybury held office from January to March, 1906.—Yours faithfully,

W. P. HENLEY MUNDEN.

Ilminster, Somerset.
May 30th, 1921.

DEAR SIR,—I enclose a note of some of the vagaries which were received at the Ministry of Pensions, which may interest your readers, some of them were in the Medical reports.

Ex raise.
Tuba Kualose.
Schore.
Capilleraries.
Pacas (Pes Cavus).
Perverated ear.
Prachistomy.
Deppmoea (Dyspnoea).
Reumitascum.
Eresyfilis.
Haemax pthymsis.
Variseal.
Mitral solitic bruit.
Neurestamia.
Appasia.
Dulness, no accompaniments.
Systolic bomb in the heart.
Hoping causes pain in the left knee.

The two following stories I cannot vouch for.

"I enclose my marriage certificate and six children. There were seven but one died. You only sent six back, her name was Fanny and she was baptised on a half sheet of paper by the Rev. Thomas and oblige.

Please sen my extra money quick as my new baby is a bottle baby and very thirsty.—Corp. J——, A.S.C."

"If you don't send John's money soon I shall have to lead an immortal life."

Yours truly,

G. NEWTON PITT.

The Photograph of Clinical Wards: Miss Strick's View.

DEAR SIR,—I should like to suggest that Dr. Astley Clarke's identification of the men in this photograph is a mistaken one. The name of the man on the left escapes me but the three others, reading from left to right, surely are E. Cronin Lowe (Southport), E. M. Harrison (Huddersfield), and George Hamilton (Chichester). My apologies to Dr. Clarke if I am proved to be mistaken myself.—Yours faithfully,

HILDRED CARLILL.

146, Harley Street, W.1.
June 3rd, 1921.

SIR,—May we take up a little of your valuable space with a few remarks about the Hospital athletics. In the first place we should like to add a few words to the account of the University of London sports, which account appeared in your last number. In it your correspondent seems annoyed with Baugh for running the quarter mile in the relay race. Baugh, who was down to run the furlong in this race, agreed in the most sporting manner to run the quarter, when it was found that the relay race was immediately before the final of the "quarter," and that Greenway would not be able to do two "quarters" without a rest.

This month we have two big athletic events taking place. The first, the Hospital Sports, is being held at Honor Oak Park next Wednesday, the 15th inst., when we hope to have as large, if not a larger, crowd than we had last year. All the usual events are being held, including the Honor Oak Park Coronation Scurry Stakes, and a very good entry has been received for each event. (N.B.—Entries for the Scurry Stakes are received on the ground.) *Admission is free* to all members, who show their membership cards, to all members of the Nursing Staff and to all competitors. Mrs. R. P. Rowlands has very kindly consented to distribute the prizes and it is hoped that so enthusiastic a supporter of the Hospital will be welcomed by every member of Guy's and all their friends.

The second event is the Inter-Hospital Athletic Competition, which will be held at Queen's Club on the 28th inst. Guy's hold the Athletic Shield now for the first time since 1895, and we are determined, in spite of the loss of the "Rosebery" Cup at the University of London Sports, that we will not give up the shield. Our team will be selected after the sports on the 15th, and will then go into serious training for the 28th, on which day we hope to see a large crowd at Queen's Club. Other hospitals will be there in force, and Bart.'s, K.C.H., and London are all hoping to beat us. Admission to the sports is 1s., tickets for the stands being 6s., 3s. 6d., and 2s. 6d. respectively.

Thanking you for the inclusion of this letter.—We are, Sir, Yours etc.,

L. G. HOUSDEN.
S. V. STRONG.
Hon. Secs
G.H.A.C.

DEAR SIR,—A Guy's nurse who commenced her training in 1890 has recently spent some weeks as a patient in a Medical Ward.

I think that some of your readers may be interested in the following observations:—

It was evident to her that many of the women came in for consultations, diagnosis and early treatment. She was struck by the number who walked into the ward and the few who arrived on stretchers, and the absence of cases admitted *in extremis*, especially those with heart disease.

A very marked change was that there were *no* "Typhoids" (in her day there were always four or five in each Medical Ward), no acute rheumatic fever, and no "trachey" children in tents by the fire.

The economic condition of the patients showed great improvement; most were suitably dressed, and a large number evidently came from fairly comfortable homes, and were prepared to contribute something to the hospital for their maintenance. The children showed a much higher level of personal care and cleanliness.

Nurse's recollection is of many sad cases of disease complicated by extreme poverty, dirt and vermin. May we not call these changes progress?—Yours, etc.,

F. A. S.

6th June, 1921.

Papers by Guy's Men.

Arthur F. Hurst, M.A., M.D. An Address on Asthma. Delivered before the Chichester and Worthing Division of the British Medical Association on February 16th, 1921.—*Lancet*, May 28th, 1921, p. 1113.

J. Lewin Payne, L.D.S., M.R.C.S., L.R.C.P. Orthodontics.—*Dental Record*, 1921, xli, p. 269.

W. M. Mollison, M.Ch. Case of Left-sided Glossopalato-vagal Paresis.—Proc. Roy. Soc. Med., 1921, xiv., Sec. of Laryngology, p. 45.

Philip Turner, M.S. Melanotic Sarcoma of the Kidney.—*Ibid.*, Sec. of Urology, p. 38.

Change of Address.

H. W. Evans, M.D., The Firs, Reedham, Norfolk.

M. B. M. Tweed, Rhodes Street, Carterton, New Zealand.

Philip Dennis Scott, 183, Maida Vale. Tel. Hamp. 2284.

Exhibition of X-Ray Photographs at the Royal Photographic Society.

An important Exhibition of X-ray Photographs has just been opened at the House of the Royal Photographic Society, 35, Russell Square, W.C., under the auspices of the Röntgen Society. Comprising upwards of 250 prints it includes a number of examples from French workers. These arrived by special aeroplane from Paris only on the day prior to the opening of the Exhibition, and for this reason it was not possible to include the details in the official catalogue, but where available short descriptive notes are attached to the prints. Of especial interest in this section is the work of the late Dr. C. Infroit, of the Hospice de la Salpêtrière, Paris. It will be remembered that this worker died recently, a martyr to science.

Drs. Vignal, Haret and Contremontez have sent very striking examples of their radiographic work, and interesting examples of metal radiography have been contributed by the firm of Giaffe-Gallon and Pilon.

Among notable examples of work contributed by radiographers in this country is a fine series of prints illustrating various abnormalities of the vermiform appendix, by Dr. C. Thurstan Holland.

The Cancer Hospital is represented by some good technical prints, noteworthy being a record of the progress of opaque meals.

The wide application of radiography is demonstrated by the prints of paintings shown by Dr. A. Chèron and the Sunic Research Laboratory; as is widely known nowadays fraud is readily detected and curiosities brought to light by its use.

Undoubtedly of historic interest are the photographs of the hands of celebrities taken in 1896—the early days of X-ray photography—by A. Campbell Swinton, Esq. The hands shown here are those of Lord Salisbury, Sir William Crookes, Lord Armstrong, Lord Kelvin and the Rt. Hon. A. J. Balfour, O.M.

Dr. Salmond, joint honorary secretary of the Röntgen Society, is represented by work of good technical quality.

Radiographers will be particularly interested in the comparative results obtained with the new Impex plates and the ordinary X-ray plates, by Dr. G. H. Rodman, the President of the Royal Photographic Society. The increased rapidity secured by the Impex plates is clearly indicated.

A series of plates taken under the difficulties of war and with a portable apparatus, by Miss Phyllis Berry and Miss Collum, of the Scottish Women's Hospital, France, illustrates some of the war-time applications of the X-ray.

The Exhibition generally is one of very considerable technical excellence, and a distinct advance over anything previously seen. The hanging of the work of radiographers in this country alongside that of workers in other countries demonstrates the advantage of different methods of procedure and should serve to help technique in the future. Perhaps the best evidence of this is seen in a series of sets of four prints produced by lay workers employed either in the radiographic departments of hospitals, or acting as assistants to qualified radiographers.

A competition for prizes offered by Dr. R. Knox, President of the Röntgen Society, has undoubtedly helped in popularising this Exhibition, and generally the entries are of a high standard. The work of Mr. Suggars, of the London Hospital, was the best, in the opinion of the judge, and it was closely followed by that of Mr. A. O. Forder, of King's College Hospital.

The Exhibition will remain open daily during the whole of June (Sundays excepted) from 11 a.m. to 5 p.m., admission free, and should certainly not be missed by anyone interested in radiography.

Guy's '89 Club.

The 26th Annual Dinner was held at Hotel Cecil on Wednesday 11th May. The President, A. Scott-Turner was in the Chair, and the other members present were, R. H. Fagge, H. M. Stewart, C. H. Fagge, E. R. Thomas, B. G. Reynolds, C. A. Ensor, J. W. Ensor, G. S. Hovenden, G. L. Eastes, H. W. Beach, J. A. Howard, B. A. Richmond, E. A. Peters, F. J. Steward, C. D. Edwards, E. T. Shorland, J. Moore, C. S. Handley, W. Tyson, W. E. Robinson, R. E. Delbruck, A. C. Hovenden, H. W. Collier, C. E. Michael, W. J. Henson, A. P. Beddard and H. J. Spon.

Messages of regret for non-attendance were received from O. Beven, L. E. Every Clayton, E. Coleman, R. F. Clark, W. L. B. Davies, E. R. Fothergill, F. A. Godson, R. H. Hayes, H. Hewetson, H. T. Hinton, B. Instone, W. H. Jewell, F. J. Nicholls, A. A. H. Partridge, L. G. Reynolds, W. J. Rowland, E. C. Taylor, J. C. V. Wilkins, E. C. Carpmael, H. A. Duffitt, M. A. Key, and T. L. Jackson. The following officers were elected for the ensuing year:—President, W. Tyson; Vice-President, E. T. Shorland; Secretary and Treasurer, H. J. Spon. The new members unanimously elected were F. S. Brereton, W. I. Bird, R. O. Moon, H. A. Munro, J. C. Peatson, C. A. Tromser, H. F. Turner, and W. F. Miller. This meeting of old Guy's men was the most successful in point of attendance since 1897, and proved a most enjoyable re-union.

Another Vignette.

AGED TWO.

Aged two with a head made for Cherubim is in Cot D. She is having tea. With little skill and much patience she is endeavouring by means of a yet undeveloped sense of tactile discrimination to manœuvre to the vicinity of her mouth a minutely polite piece of bread and butter. Sometimes she succeeds, more often it returns precipitately to her lap. A crowd of students swarm round the cot, and a nice old man placing his hand on the rail talks to them. She is indifferent; the students to her might be statues. She gazes with wondering eyes up at the face of the nice kind old man, and a piece of bread and butter that has been safely conveyed to the region of her chin falls back into her lap. Five little round pink fingers reach out to touch his hand. The statues smile, but she does not notice them, for he, this god is cold to her homage. Still he talks to these dull men, these ordinary mortals, and ignores her. Disconsolate she returns to her bread and butter, again it reaches her chin, she raises her eyes to her Zeus, stretches out a tiny crust to touch his hand. He smiles, he looks down at her, and lo! he speaks—she has conquered. She does not know what he has said, but the statues laugh. She does not laugh, for to her it would be sacrilege. He has spoken to her, the feminine in aged two is satisfied. She searches for another piece of bread and butter and continues tea.

W. G. B.

Guy's Hospital Dental School.

Post-Graduate Lectures.

Two lectures on "Local Anæsthesia in Dentistry" will be given by Mr. F. N. Doubleday, L.R.C.P., M.R.C.S., L.D.S., on Thursday, June 30th, and July 7th, at 5 p.m.

Three lectures on "Advanced Dental Prosthetics" will be given by Mr. W. Kelsey Fry, M.C., L.R.C.P., M.R.C.S., L.D.S., on Thursday, July 14th, 21st and 28th, at 5 p.m.

The above lectures will be given in the Anatomical Theatre.

Cards of admission may be had on application to the Dean, Guy's Hospital, London Bridge, S.E.1.

Pass List.

University of London.

THIRD (M.B., B.S.) EXAMINATION FOR MEDICAL DEGREES, MAY, 1921.

Honours.

*R. C. B. Ledlie.

*Distinguished in Surgery.

Pass.

J. Gaymer Jones. C. H. Marshall.
E. H. L. Leclezio. R. W. Warwick.

Group I.

H. T. Le Vieux. W. H. Simmons.

Group II.

S. Rose. K. M. C. Woodruff.

Notices.

Junior Guyite Club.

A Dinner of the above Club will be held on June 16th, at the Restaurant Frascati (Alpha Salon), 7.30.

A. E. Price, Esq., M.S., M.D., in the Chair.

Price of Dinner 12s. 6d. (Wine not included).

Members are requested to answer before June 11th.

Reviews.

Manual of Bacteriology. By R. Tanner Hewlett. Seventh Edition. (Messrs. J. and A. Churchill.) Price 21s.

The fact that this volume has reached its seventh edition is itself sufficient indication as to its merit. The book may be recommended with confidence as a good student's manual, brought up-to-date by extensive revision and alteration.

In the earlier pages the American Committee's suggestions on the classification of bacteria have been adopted.

Among new methods, Mutch's single cell culture and modifications of Gram's method have been introduced.

The section on the microscope has been rewritten, and contains a good account of the method of dark-ground illumination. The chapters on septic diseases, pneumonia and epidemic influenza have been revised, and the section on the Wassermann reaction has been entirely rewritten.

Among the additions to this volume are a new account of botulism, and a short discription of encephalitis lethargica.

The type is excellent and the illustrations good. The introduction of coloured plates would improve the book.

Prosthetic Dentistry. By Douglas Gabell, L.R.C.P., M.R.C.S., L.D.S. (Oxford Medical Publications.) Price 12s. 6d.

This work will supply a very useful addition to dental bibliography as hitherto the chair-side work of the dental surgeon as regards denture-making, has been badly neglected. It may be held that each practitioner will acquire his own methods with experience and practice, but some kind of guide to those who have had no very wide experience will be of considerable value. This book will also be of very great use to the pupil when he first has to make dentures from beginning to end, for at present except for some more or less useful chapters in large works on mechanical dentistry, such pupils cannot make themselves familiar with fundamental principles before proceeding to the important work of denture-making.

In addition to chapters dealing with the various stages in the ordinary procedure, there are several very valuable chapters, such as, "Preparation of the Mouth," "Movements of Jaw," "Setting up of Teeth," "Complaints," and a very useful, but unfortunately rather brief, concluding chapter on "Refits, Additions and Repairs," which provides a number of useful hints which ought to be of much assistance to the average busy practitioner, and more so the pupil and student.

The subject is treated from the scientific, artistic, and hygenic points of view, some of the chapters are well illustrated, and the book is essentially practical. It seems a pity the author did not see fit to add something about obturators and regulating appliances to complete the work, but perhaps a separate work on these subjects may be forthcoming later.

This collection of details connected with denture-making from the point of view of the dental surgeon arranged systematically, should be of great value to students and practitioners.

The Care of Eye Cases. By R. H. Elliot. (Published by Messrs. Froude, Hodder & Stoughton.) Price 12s. 6d.

The aims of this book as set out in the preface are, firstly to give the nurse in charge of eye cases an idea of the manner in which the remedies used in eye diseases act, and to so train her that she may apply them with more skill and intelligence than she would obtain from a mere perusal of the bed letter. Secondly, the author desires to give a general idea of the more important eye conditions with their most prominent symptoms. The book is accordingly divided into two parts. The first contains a detailed account of the methods of eye therapeutics. The author gives full instructions as to the manner of applying drops and ointments, the proper way to wash out an eye, and the prevention of infections. This section contains many useful "tips," many of which the author has originated. This section also contains reference to instruments, such as perimeters, tonometers, and ophthalmoscopes, but while the scope of each is discussed no directions for use are given. Thus the author suggests that fields of vision can quite adequately be taken by a nurse, and indeed such is his practice, but he says nothing about the manner of using a perimeter, and recommends the nurse to seek instruction from her own surgeon. In this and several other cases the fear of being dogmatic rather detracts from the value of the book.

In the second section the author's fear of dogma prevents him giving anything but the most meagre and often quite useless indications as to the treatment to be adopted.

The book closes with an appendix which contains lists of instruments used in the various operations, together with a remarkably full series of illustrations of the instruments themselves.

A good book on the whole from which a nurse will glean much useful information, but one which would have had infinitely more value if the author had been less afraid of the accusation of leaving the nursing sphere and entering the surgeon's.

Materia, Medica, and Pharmacy for Medical Students. By R. R. Bennett, B.Sc., F.I.C. Fourth edition. (Messrs. H. K. Lewis, London.) Pages xxiii + 264. Price 7s. 6d. net.

This handy little book should be in the possession of every medical student. It is of a most convenient pocket size, and is printed and bound in an excellent manner. It is intended chiefly for students preparing for the London University M.B. degree, but students preparing for the examinations of the Conjoint Board will also find it immensely useful. It contains a concise account of the drugs, chemicals and compound preparations of the British Pharmacopœia, including the source, character, uses, and dose of each.

Of considerable value to the examinee are the two tables of doses at the end of the book, the first

table with the substances arranged in alphabetical order, and the second with the substances arranged in order of increasing minimum dose.

The present edition has been enlarged by the addition of further information with regard to the therapeutic uses of the drugs, and the diseases in which their preparations are given, information which increases the interest with which the book is read.

The Medical Annual, 1921. (Published by Messrs. John Wright and Sons, Ltd., Bristol, and by Messrs. Simpkin, Hamilton Kent and Co., Ltd., London.) Price 20s. net.

This work has now reached its thirty-ninth year of publication and is so well known to all who are interested in medicine and surgery, that it is unnecessary to do more than refer to a few of the multitude of articles, which are to be found in its pages. As in previous years the individual contributions are from the pens of well known authorities either in this country or America, and each article is followed by a bibliography, in which is given references to all important work on the subject done during the preceding year. For the busy practitioner who wishes to keep abreast of recent discoveries at a minimum of trouble and expense to himself we can most heartily recommend the *Medical Annual*, in fact it is hardly necessary to do so, as its value has been thoroughly proved in previous years.

No attempt can be made within the limits of a review to deal in detail with even the longer articles in the book. On of the most interesting is that by Ramsay Hunt on Encephalitis Lethargica, in which the voluminous literature that has grown up on the subject is summarised. On the subject of the Chemistry and Cytology of Blood there are two articles by O. C. Gruner, in the latter of which Pappenheim's posthumous work is discussed. We fear that even with the aid of the diagrams provided most readers will find considerable difficulty in mastering the new conceptions of hæmatology outlined in the article.

Among the numerous articles on surgical subjects there is an excellent review of the surgery of the stomach by Sherren. Though the statistics of ultimate results of operation in gastric and duodenal ulcer seem more favourable than some might expect, it is satisfactory to read that "according to the teaching of those with the largest experience in this (gastric) branch of surgery gastro-jejunostomy is unjustifiable in the absence of a definite lesion." Were this dogma taken to heart by all surgeons we might hear less of the unsatisfactory results of gastro-jejunostomy.

Space forbids us further to deal with individual contributions. It can, however, be safely asserted that no work of real importance during the past year has gone unnoticed.

In adition to its main subject matter the *Medical Annual* contains a list of the principal medical works and new editions published during 1920, classified according to their subject. There is also a list of medical institutions, spas, etc., and a trade directory. The book is well illustrated throughout with many plates, and the printing and paper leave nothing to be desired.

Athletic Sports.

The heats for this year's Hospital Sports will be run off on Monday next, 13th inst., at 7.0 p.m. It is regretted that, owing to a cricket match, they cannot be started earlier, and it is hoped that all concerned will make a point of being present. The events that evening will be:—

100 yards handicap (heats); Throwing the hammer; 220 yards scratch (heats); half-mile scratch; 120 yards hurdles scratch (heats); 440 yards handicap; one mile scratch; 120 yards hurdles handicap (heats); to be run off in that order.

Lawn Tennis.

The Guy's Hospital Lawn Tennis Club played St. Mary's in the 1st Round of the Hospital Cup, on May 27th, 1921, and won by 11 matches to nil.

The Hospital was represented by:—M. Jackson (Capt.), L. Nurick, J. Jacobsz, B. Keyter, A. Daneel, P. J. Albertijn.

On Saturday, May 28th, 1921; Guy's lost to University College, by five matches to four.

Shaw—Bekker won 2, Phillips—Hodgkinson won 1, Cordon—Potts won 1.

On Sunday, May 29th, 1921, Guy's I. beat Dulwich on their ground by 6—3.

Jackson—Nurick won 3, Daneel—Neser won 3, Keyter—Jacobsz lost 3.

Daneel and Neser shaped very well and should be a good combination.

Pavy Gymnasium.

The Annual General Meeting of the Pavy Gymnasium was held on June 2nd at 1 p.m., in Classroom 2, Mr. Mollison being in the Chair.

The Officers were elected as follows:—

President: A. W. Ormond, Esq., C.B.E.

Treasurer: W. M. Mollison, Esq., M.Ch.

Committee: Messrs. H. Chapple, M.Ch., S. P. Meacock, J. D. S. Thomas, R. F. H. Duncan, W. H. Foy.

Hon. Secs.: Messrs. J. A. F. Denyssen, N. L. Lloyd.

It was decided to ask Messrs. Alf. Hewitt and G. F. Baker, and Capt. Felix Gravé to act again as instructors in the coming season, instruction to commence in October.

Report on Season 1920—21.

During the past year, the chief event among the activities of the Pavy Gymnasium has been the Inter-Hospital Boxing Competition, which was held on March 8th at the National Sporting Club, and which resulted in a win for Guy's who headed the list with 16 points. The Challenge Cup, however, which should now be adorning the "Spit" is only a myth, since it was lost during the years of the war, and cannot be traced.

The boxing enthusiasts were also fortunate in obtaining a fixture with Oxford University, and it is hoped that this will become an annual affair. This year Guy's tied with Oxford, each winning three events, one Guy's representative being unable to turn up through illness. The instructor has once more been the indefatigable Alf. Hewitt, and we have nothing but praise for the way in which he has helped us.

The Gymnastic Classes have also been very encouraging, as many as sixteen turning up on some evenings. We were able to obtain two fixtures, one with the City of London School and the other with Mill Hill School, both of which we lost. This is not surprising, considering the numbers from which we had to choose our team.

Both opponents have expressed their desire for a return of the fixture during the next season.

The instructor has again been G. F. Baker, whose keen interest in his pupils is a source of delight to all who work with him.

Fencing was revived during the last season, an enthusiastic class of ten to fifteen pupils receiving instruction during the first two months from W. H. Foy, a member of the Gym. Committee, with varying degrees of success, but exams. and an inability to overcome the initial stiffness caused the class to diminish towards the end of the season to seven faithful adherents, and Capt. Felix Gravé, who is probably Europe's most skilled swordsman, was appointed instructor. Considerable progress was made and it was hoped to re-contest the Inter-Hospital Challenge Trophy, but an absence of material to challenge in other hospitals caused the hope of contest to be abandoned.

With as great an enthusiasm, and more participants, there is every possibility of raising teams for foils, epées and sabre for open contests next season, and there are also a number of good matches which could be arranged with the various London sword clubs, military schools, and other hospitals.

W. H. Foy succeeded in reaching the last qualifying round for the semi-finals of the British Amateur Fencing Championships this year. His failure to proceed further can only be put down to an acute depression caused through not seeing any other London hospital swordsman present to support the common cause.

Water Polo.

GUY'S v. MARCIANS' S.C.

Short time was played owing to the low temperature of the water at Fulham Baths on Wednesday, May 11th, when Guy's beat the Marcians' Swimming Club by two goals to one, in a well contested game. Cohen, who was unfortunately absent, was replaced by Kempster at centreforward.

The first goal was scored for the Hospital by Painter, who flicked the ball into the net after a characteristic swim to the opposing goal line. Shortly afterwards Kempster increased the lead by pushing over from a mêlée in the goal mouth.

After half-time the Marcians' made several strong attacks, but good work by Hutchinson at back, and by Sampson in goal, prevented a score until late in the game, when the opposing centre-half, swimming away from his man, shot in excellent fashion.

Some good passing by Theis followed, but was not turned to account owing to our forwards' lack of shooting power.

Time was blown with the Hospital leading 2—1.

The team shows more understanding after its first match, but still requires serious practice in combination and shooting.

Cricket.

First XI. Scores.

GUY'S v. BECKENHAM.

Beckenham.

A. M. Lewis, c Ensor b Faure	33
R. G. Howell, b Biddle	16
F. J. Seabrook, b Taylor	56
P. J. Aste, c Shearar b Shaw	6
C. S. Hurst, c Biddle b Shaw	24
J. E. Williamson b Taylor	2
J. K. Stenning, b Shaw	0
H. G. Chandler, run out	16
F. G. Clark, not out	17
C. J. Capes, not out	5
Extras	18
Total (for 8 wickets)	187

W. A. Barnes did not bat.

Guy's.

L. C. Willis, c Barnes b Stenning	48
A. G. Ensor, b Clarke	50
C. G. Curle, c Capes b Clarke	2
G. D. Shaw, b Clarke	10
T. Wooldrige, c and b	7
L. B. Helder, b	24
G. L. Shearar, b Capes	11
J. C. Faure, not out	1
Extras	19
Total (for 7 wickets)	172

Did not bat: F. J. Biddle, H. W. Taylor, R. C. May.

GUY'S v. SEVENOAKS.

Played at Honor Oak Park, Saturday, May 14th, 1921.

Sevenoaks.

H. J. Taylor, c Ensor b Van Schalkwijk	74
T. A. Grose, b Van Schalkwijk	12
H. Thompson, st May b Hewetson	42
A. Cochrane, b Van Schalkwijk	60
H. Holten, b Van Schalkwijk	9
P. Roger, lbw Van Schalkwijk	1
H. L. Battersea, c Helder b Van Schalkwijk	0
H. T. Cross (Capt.) c Biddle b Van Schalkwijk	27
H. Fuggle, run out	1
A. Norwood, b Shaw	3
S. W. Wells, not out	0
Extras	29
Total	258

Bowling:—J. Van Schalkwijk, 7 for 90; G. D. Shaw, 1 for 54; Hewetson, 1 for 18; F. J. Biddle, 0 for 44; T. Wooldridge, 0 for 23.

Guy's.

L. C. Willis, c Grose b Wells	10
A. G. Ensor, b Wells	16
A. Hirschberg, b Wells	5
G. D. Shaw, c Cochrane b Taylor	35
T. Wooldridge, b Taylor	4
L. B. Helder, c Grose b Taylor	25
J. Van Schalkwijk, b Wells	4
G. L. Shearar, b Wells	0
F. J. Biddle, b Wells	6
J. C. Hewetson, b Wells	0
C. G. Curle, not out	0
Extras	7
Total	112

Bowling:—S. W. Wells, 7 for 36; H. J. Taylor, 3 for 40; H. L. Battersea, 0 for 29.

GUY'S v. PRIVATE BANKS.

Played at Catford on Whit Monday.

Guy's.

L. C. Willis, c and b A. J. Smith	1
C. G. Curle, b H. E. Duff	13
G. D. Shaw, c and b H. E. Duff	6
T. Wooldridge, b A. J. Smith	39
J. Van Schalkwijk, b A. J. Smith	10
L. B. Helder, c Bennett b A. J. Smith	33
F. J. Biddle, b A. J. Smith	0
G. L. Shearar, c and b A. J. Smith	52
C. S. Johnson, b Monk	13
J. C. Hewetson, not out	4
P. Harvey, b Monk	0
R. G. Pengelly, c Bennett, b A. J. Smith	4
Extras	23
Total	198

Private Banks.

W. F. Harden, lbw b Van Schalkwijk	16
E. J. Thomas, c Van Schalkwijk b Biddle	40
A. J. Smith, b Shaw	12
E. J. Morris, b Shaw	0
C. R. Ingersole, b Wooldridge	0
E. W. Skinner, b Wooldridge	6
H. V. Buckingham, run out	1
H. E. Duff, b Biddle	7
J. P. Monk, not out	6
M. H. Cooper, b Wooldridge	2
J. L. Bennett, b Wooldridge	0
S. B. Fagan, c Willis	4
Extras	12
Total	106

Bowling:—Wooldridge, 5 for 19; Shaw, 2 for 18; Biddle, 2 for 33; Van Schalkwijk, 1 for 24.

GUY'S v. R.A.F., UXBRIDGE.

This match was played on May 18th, 1921 (away).

Guy's.

L. C. Willis, c Wakefield b Lawson	58
A. G. Ensor, b Lawson	17
J. Van Schalkwijk, b Woods	8
G. D. Shaw, b Woods	0
T. Wooldridge, c and b Woods...	21
L. B. Helder, not out	26
G. L. Shearar, c Wakefield b Lawson ...	16
C. G. Curle, not out	17
Extras	19
Total (for 6 wickets dec.) ...	182

Did not bat: H. B. Cahill, D. E. C. Eglington, R. C. May.

R.A.F.

A.C.1. Lewis, c Shearar b Van Schalkwijk ...	13
A.C.1. Filkins, b Shaw	0
Capt. Lawson, b Shaw	0
F.O. Fenwick, b Shaw	12
Capt. Lees, run out	0
F.O. Wakefield, b Van Schalkwijk	20
F.O. Baynes, c May b Van Schalkwijk ...	14
P. Woods, not out	33
Sq.Lr. Hicks, c Wooldridge b Van Schalkwijk	4
A.C.2. Clifton, not out	4
A.C.2. Buchanan, b Shaw	0
Extras	8
Total (for 9 wickets)	108

Bowling:—J. Van Schalkwijk, 4 for 38; G. D. Shaw, 4 for 42; T. Wooldridge, 0 for 20.

GUY'S v. HONOR OAK.

Played on May 21st, 1921 (at home).

Guy's.

L. C. Willis, c Kempton b Lockton	0
A. G. Ensor, b Lockton	9
H. B. Cahill, b Lockton	0
G. D. Shaw, b Lockton	7
T. Wooldridge, not out	88
J. Van Schalkwijk, c Abel b O'Gorman ...	0
L. B. Helder, b O'Gorman	48
G. L. Shearar, b O'Gorman	8
C. G. Curle, b O'Gorman	4
F. J. Biddle, b Lockton	1
R. C. May, b O'Gorman	5
Extras	20
Total	190

Honor Oak.

W. Gracey, b Van Schalkwijk	5
W. T. Cook, b Van Schalkwijk	1
E. G. Hayes, b Biddle	51
R. C. Alwin, b Van Schalkwijk	4
A. Kempton, lbw b Van Schalkwijk	2
L. Thompson, b Wooldridge	30
G. A. Abel, c Van Schalkwijk b Wooldridge	7
C. Wise, lbw b Biddle	0
J. H. Lockton, not out	5
J. O'Gorman, c Biddle b Wooldridge	0
A. R. Thorpe, c Ensor b Wooldridge	4
Extras	19
Total	128

Bowling:—J. Van Schalkwijk, 4 for 43; G. D. Shaw, 0 for 11; F. J. Biddle, 2 for 25; T. Wooldridge, 4 for 30.

GUY'S v. U.C.H.

First Round Cup-Tie.

This match was played at Perivale on May 24th, 1921.

U.C.H.

First Innings.

G. O. Montgomery, not out	31
J. A. Hadley, b Van Schalkwijk	2
S. K. Montgomery, b Van Schalkwijk	2
R. Massingham, b Shaw	3
O. D. Gladish, b Van Schalkwijk	2
W. J. G. Walker, c Shearar b Van Schalkwijk	2
G. D. Buck, b Shaw	6
A. Burlingham, b Shaw	0
L. W. Hale, b Van Schalkwijk	6
K. S. Lism, b Shaw	9
C. W. Evans, run out	2
Extras	5
Total	70

Guy's.

First Innings.

L. C. Willis, c G. O. Montgomery b Gladish	8
A. G. Ensor, c Gladish b S. K. Montgomery...	1
J. Van Schalkwijk, b S. K. Montgomery ...	0
G. D. Shaw, b S. K. Montgomery	11
T. Wooldridge, lbw b Gladish	25
L. B. Helder, c Walker b G. O. Montgomery	3
G. L. Shearar, b G. O. Montgomery	79
H. B. Cahill, b R. Massingham	6
C. G. Curle, c G. O. Montgomery b Gladish	7
F. J. Biddle, c Hale b Gladish...	2
R. C. May, not out	16
Extras	16
Total	174

U.C.H.

Second Innings.

G. O. Montgomery, c May b Shaw	65
J. A. Hadley, b Wooldridge	20
S. K. Montgomery, run out	41
R. Massingham, c Ensor b Shaw	9
O. D. Gladish, not out	38
W. J. G. Walker, b Shaw	0
L. W. Hale, not out	3
Extras	11
Total (for 5 wickets dec.) ...	187

Did not bat: G. D. Buck, A. Burlingham, K. S. Lism, C. W. Evans.

Guy's.

Second Innings.

L. C. Willis, b G. O. Montgomery	24
A. G. Ensor, lbw b G. O. Montgomery ...	0
G. D. Shaw, b G. O. Montgomery	4
T. Wooldridge, b Gladish	1
L. B. Helder, not out	35
G. L. Shearar, not out	12
Extras	8
Total (for 4 wickets)	84

Did not bat: J. Van Schalkwijk, H. B. Cahill, C. G. Curle, F. J. Biddle, R. C. May.

Bowling (First Innings):—J. Van Schalkwijk, 5 for 34; F. J. Biddle, 0 for 12; G. D. Shaw, 4 for 19

Bowling (Second Innings):—J. Van Schalkwijk, 0 for 73; F. J. Biddle, 0 for 19; G. D. Shaw, 3 for 50; T. Wooldridge, 1 for 33.

SECOND XI.

The Second XI. have played seven games this season. The first, that against Cyphers Second, was abandoned owing to rain. Of the others, we lost to Old Priorians, Goldsmith's College and Honor Oak Second, and beat King's College, University College Hospital, and the Staff.

The team as a whole have not settled down to consistent form as yet, but a great improvement has been made since the first games. More confidence is required in batting and practice in bowling. The only consistent bowler so far has been Bowen, but considerable talent is present to be developed. More use should be made of variations in pace.

The fielding so far has been bad; a number of catches have been dropped, particularly in the slips, and few fielders seem to realise the importance of smart ground fielding and the advantages of throwing in a full toss when near the wicket. Practice is all that is necessary.

The capabilities of the team when put to it were shown in the first round of the Junior Inter-Hospital Cup. The bowling was good and dismissed U.C.H. for 41; nearly all the batsmen scored well, and the tail, comprising Thomas and Bowen, wagged to the extent of 84—a capital exhibition of sound hitting.

In the match against the Staff, which was well attended, the Hospital employees made 107, of which 73 were made by Hayward. His innings was the best the second team have seen this season, and going in first and carrying his bat it was a pleasure to watch him. The students' team fared rather badly at first, but managed to win in the end, chiefly owing to an excellent century by H. A. H. Harris, who also went in first and was last man out. The total score for the Hospital was 190.

The second round of the Junior Inter-Hospital Cup is against Bart.'s at home on Monday, 13th. It is hoped that more supporters will be present than at the last match.

Boat Race.

The four-oared race for the Inter-Hospital Challenge Cup, which is an annual event, was rowed at Putney on the 26th of May. The race was between Guy's as holders and St. Bartholomew's as challengers, and resulted in a win for Guy's by three lengths. The race was timed to start at 4 p.m., and St. Bartholomew's, winning the toss, chose the Surrey station, which perhaps carried with it a very slight advantage.

Both crews got clear away from the stake boats in good style, Bart.'s striking 18 in the half minute to Guy's 16. After half a minute, however, one of the rudder lines in the Guy's boat broke, and as the danger of a foul was imminent the umpire stopped both boats.

As this occurred almost at the start it was decided to start the crews again.

This was done, and a very interesting race ensued; the crews started again at about the same rate, Guy's rowing the slower stroke, but being longer in the water and holding their opponents, they had gained a length by the time Fulham football ground was reached. Bart.'s spurted again and again, but seemed to get rather flustered and lost their rhythm and got shorter. They also lost a fair amount of valuable water by going too far into the "bay" at the mile-post; the result was that this, coupled with excellent steering on the part of Guy's, made the result certain when Harrod's wharf was reached, and Guy's finished in very good style three lengths ahead.

The points which gave us the race were good steering, a long steady stroke against the head wind, and realising what a lead at the start meant in cox-swainless rowing, our opponents rowed a very sporting, and plucky race.

The thanks of the Club are due to Mr. H. A. Arnold of Westminster School who so kindly took on the duties of umpire, and Mr. H. S. McLaren, of the London Rowing Club, who coached the crew.

Two launches followed the race carrying the umpire and spectators.

Considering the difficulties and the short time the Guy's boat had been practising it reflected very creditably on all in the boat to go in for and win the race against a crew who had been rowing for a longer time. For various reasons only one of last year's members was available, R. S. Chambers, and the prospects at one time looked distinctly gloomy. For this reason the way the crew rowed was doubly gratifying, Chambers at stroke and Parsons at 3 were particularly in evidence as very sound and dependable oarsmen.

The names and weights of the crews are as follows:—

Guy's—

(Bow) A. S. Gough, 9st. 8lbs.
2. C. C. Hughes, 10st. 9lbs.
3. K. O. Parsons (steers) 13st.
(Stroke) R. S. Chambers, 10st. 4lbs.

St. Bartholomew's—

(Bow) O. O. Fairbairn, 10st. 6lbs.
H. H. Fisher, 10st. 12lbs.
B. M. Tracey, 11st. 5lbs.
A. S. Struthers, 11st. 6lbs.

United Hospitals Swimming Club.

There will be an Inter-Hospital Nurses' Swimming Cup competed for this year, the final of which will be held on the Gala night. Considerable interest is being taken by a number of the Hospitals, so the actual final should not be without some excitement. During the evening of July 1st the President of the Bath Club, Lord Desborough, has kindly consented to attend and will in all probability present the prizes.

Up to now there has been little or no interest taken in the swimming handicap events, except by the active members of the Club. These events were put in for the sole purpose of enabling students, who were not as fast as some of the other people, to benefit by their handicap and so help them to stand a better chance of winning in any of the races. During the next three weeks will all "triers" enter, as there is nothing more exciting than a well contested race.

The tickets for the Gala night are limited to 300 and unfortunately all those who may wish to come will not be able to get a ticket, but it has been decided that competitors will receive precedence before anybody else in the demand for seats.

Swimming Club.

There has been considerable disappointment this term due to the coal strike that such a number of matches have had to be scratched. It is hoped that with brighter news the remainder of the fixtures will be fulfilled. Consequently, all members are requested to practice as much as possible.

GUY'S v. ST. JOHN'S COLLEGE, CAMBRIDGE.

Swimming and Water Polo fixtures were swum off at Shoreditch Baths on Friday, May 27th, at 8 p.m.

Result of Swimming:—

100 *Yards.*—1, St. John's; 2, Guy's; 3, St. John's; won by 4 yards. Time, 69 2-5 secs.

50 *Yards.*—1, St. John's; 2, Guy's; 3, St. John's; won by a touch. Time, 28 1-5 secs.

Team Race.—1, St. John's; 2, Guy's; won by a touch. Time, 2 mins 1 1-5 secs.

Water Polo Match.

From the commencement of the game Guy's showed their superiority in shooting, combination, and handling the ball, though at times the opposing team made some very fine rushes. Cohen and Painter excelled themselves in every way, the former scoring two beautiful goals and the latter one from inside his own half. Result, 3—0.

Swimming Team.—Painter, Richards, March, Jarman, Hutchinson, Dingle, Kempster.

Water Polo Team.—Sampson, Wakeford, Harvey, Painter, Theis, Cohen, Hutchinson.

Births.

HANCOCK.—On 28th May, 1921, at Trevaunance Cottage, Howe Green, Chipstead, Surrey, the wife of Allen Coulter Hancock, M.C., M.R.C.S., L.R.C.P., D.P.H., of a son.

PALMER.—On May 7th, 1921, the wife of Dr. A. S. Morton Palmer, of 103, Marine Parade, Worthing, a son.

SCOTT.—On 2nd June, to Marguerite Louise, wife of Philip Dennis Scott, a son.

WEBSTER.—On June 2nd, 1921, at Tybwyn, Merthyr Tydfil, to Mr. and Mrs. V. T. P. Webster, a son.

Marriage.

FAWKES—JENKINS.—On June 1st, 1921, at Holy Trinity Church, Northampton, the Rev. Herbert Beattie Fawkes to Gertrude Jenkins.

ED.—A. T. R.

GUY'S HOSPITAL GAZETTE.

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Passim.

IT seems that the nurses are not going to let themselves be outdone by the men this year in the field of inter-hospital sport. They have already successfully passed through the first round of the Inter-Hospital Nurses' Lawn Tennis Tournament, and in doing so have beaten King's College Hospital, who last year defeated them in the semi-final round of the tournament. The battle is not yet over, there are still many good teams left in the competition; but this initial victory augurs well for Guy's, and we hope soon to see this cup brought back to the Hospital.

We are glad we are able to publish on another page a detailed account of this match, for considering the number of nurses who are readers of the GAZETTE, there is little enough in it to meet their particular interests. Before the war, there used to appear regularly each fortnight a column of Nursing News, but in the stress of war conditions when paper was short and time and tempers shorter, this column dropped out. Since the return of more normal conditions little or nothing has been done to make the GAZETTE a more readable and a more interesting publication. The fact that we have at last received one item concerning the activities of the nurses, is a step in the right direction. We would like to be able to publish some nursing news every fortnight, but this cannot be done without the co-operation of the nurses themselves. Most of them seem to have a very poor opinion of their own powers of composition and cannot be induced to make the least attempt at writing anything for publication. Yet they will write long letters describing their hospital life. It is no more difficult to record in a few lines any small incident of interest which may have occurred in the Hospital or the Home. It is surprising how interesting such information may prove to those nurses who have left the Hospital, and who, for want of some such budget of news, are fast losing touch with their alma mater. And these nurses too can help us by sending us occasional short notes of their experiences and successes in the world outside the Hospital.

It must be recognised that everything works in a vicious circle. If we can make the GAZETTE a more interesting journal we may hope to get more subscribers. The more subscribers we have the more advertisers we will get, and as it is the advertisers who eventually pay for the publication of any progressive paper, the more advertisements we get the larger we shall be able to make the GAZETTE, and the more space we shall have to spare for still more interesting paragraphs.

One of the several plaints brought against the GAZETTE is that it has become far too staid. We are told that we devote too much space to the publication of clinical lectures and reports of societies, which, useful though they may be, do not provide that amusing reading which should be found in the pages of a hospital or college journal. We can only say that we appreciate the wit and ingenuity of those articles written in a lighter vein, which we seem always able to find in the columns of other contemporary hospital journals but never among the manuscripts sent to us for publication. If only we were to receive such copy we should have no hesitation in publishing it. We therefore appeal to our readers to help us with contributions or suggestions which will help to make the GAZETTE more popular and more successful.

THE Honorary Secretary of the War Memorial Committee has sent us for publication a notice (appearing on page 240), in which he details the arrangements for the allotment of tickets for the unveiling of the War Memorial on July 15th. He has asked us to explain that he intends sending invitations to the relatives of each of the fallen men. There will be a special space reserved for them as our guests of honour on this day. The Honorary Secretary however has found that many of his letters go astray and many more are returned to him through the dead letter office. This is only to be expected when one considers that the only address which is available in many cases is that which was furnished to the Medical School Office perhaps ten or fifteen years ago, during student days.

So if any relatives have not received their invitations by the end of next week, the Honorary Secretary would be glad if they would write and ask him for tickets.

THE two lectures upon general practice which were promised us have now both been delivered. Both were well attended (on each occasion the Clinical Theatre was crowded), and both were greatly appreciated, for we did not have to sit and listen to a long and tedious harangue such as it is our fate to meet occasionally in this theatre. On the contrary, each of these so called lectures was in reality a most interesting and at times most diverting series of stories about the opportunities and the trials of general practice. Both of our lecturers had served many years in practice, and both drew upon their experience to illustrate their precepts. We are very grateful to them for taking the trouble to come to Guy's to lecture, and we also thank them for allowing us to publish their lectures. The first one, by Dr. Seymour Price on "Some Points on General Practice," will be found in this GAZETTE on page 248. We hope shortly to publish Dr. Stewart's lecture. We shall also have the pleasure of publishing a series of letters of advice written by a general practitioner for the guidance of those who are about to encounter the difficulties of practice. These will deal week by week with many of the minor details of fees and partnerships, of laws and of etiquette, which often prove such puzzles to the novice.

THE Athletic Sports were held at Honor Oak Park on the Wednesday before last. In spite of the counter attraction of Royal Ascot, it drew quite a fashionable attendance of Sisters, Nurses, and members of the Senior Staff. Those that were there could hardly count their time ill-spent for they witnessed some very fine athletics. Foremost, of course, there was Steyn's magnificent feat of breaking three hospital records in one afternoon. This he did in the quarter mile, in the 220 yards, and in the long jump. For the rest, perhaps, the most exciting event was the well fought tug-of-war between medical and dental teams. This, the dental team, which showed the better staying

power, won by two pulls to one after twice having been within a foot of defeat.

The race for the Scurry Stakes proved amusing, though after the first few heats it became obvious that there was very little competition, and that one of the donkeys usually had things all his own way.

The success of the sports was undoubtedly almost entirely due to the hard work done in their preparation and execution by Mr. Housden, the Honorary Secretary. Not satisfied, however, with this success, he has been urging us to give the greatest prominence to his appeal for the support of an enthusiastic cheering multitude of Guy's men at the Inter-Hospital Sports. He shows that the Hospital has no easy task before it if it is to retain the Athletic Shield, and he asks for a thousand supporters at Queen's Club to help our team of athletes to defy the attempts which the other hospitals are going to make to take it from us.

WE hear that the Westminster Hospital have in all due seriousness issued a challenge to all comers in the ancient sport of shove-ha'penny. For twenty years now the game has been assiduously practised there. Having at last become highly proficient the Westminster men have come out into the open and proclaimed themselves champions. They have had their photograph taken (all of them dressed up in nice white coats) and published in the daily press. Reporters assure us that at Westminster Hospital they think of nothing else but shove-ha'penny from morning till night. They play it before breakfast, between lectures, during operations, and even after dinner at a time when normal individuals are sitting down to their evening rubbers of auction-bridge.

Nevertheless, we do not think that Guy's should leave this challenge unanswered. The Westminster men must be shown that they do not become champions by merely stating their excellence at the game. We retain memories of many an hour spent practising shove-ha'penny in the Dissecting Room. So we have consulted Dr. Hancock, who is Hon. President of the G.H.S.H.C., and he has consented to act as coach to the challengers. A course will be laid out in the Dissecting Room, and half-pennies will be provided. We ought surely to be able to put into the field a team which will be able to beat those seekers of publicity at their own game.

If we cannot do this, we can ourselves issue a challenge to them to a match in that amorphous game, part baseball and part cricket, which is now played nightly in the park.

IT must be a source of considerable satisfaction to those members of the dental profession who have fought so persistently for the establishment of permanent Dental Services in the Navy and Army to see the announcement of the first entrance examination for admission to the Royal Naval Dental Service which we print in another column. Nine commissions as Surgeon Lieutenants (D) are offered for competition.

Further we are glad to note that Mr. Montagu Hopson has been appointed one of the two examiners by the Admiralty.

THE letter which appeared a short while ago in the GAZETTE protesting about the inefficient state of the clinical laboratory seems to have brought the campaign for the renovation of this important laboratory to a head. We find now that a laboratory-boy has been appointed, and is keeping the room in order. Our only complaint now is that the centrifuge is still out of use. When the authorities find how useful this laboratory is proving they may perhaps consider the possibility of equipping a similar one in the surgical buildings. May we suggest that the room on the second floor under the clinical

theatre which is now used by a few men as a cloak room, could with slight trouble and small expense be adapted for this purpose.

GUY'S succeeded in passing the second round of the Inter-Hospital Cricket Competition, by beating Bart's. on June 14th. Guy's scored 326 for 5 (declared) (Willis 80, Wooldridge 61 not out), Bart's. being all out for 192. We hope to publish a report of this match in our next issue.

Pass List.

L.D.S.

FINAL EXAMINATION. JUNE, 1921.

Part I.

H. R. Ward.
V. L. Sunderland.
E. C. Bevis.
G. Curle.
A. Havenga.
L. G. Hemmings.
E. J. Joels.
S. Masey.
H. J. Luck.
E. C. Packham.
W. J. Olivier.
C. M. A. Pauw.
H. H. Pickett.
J. F. Pilbeam.
E. M. Power.
H. J. Raubenheimer.
J. H. Reid.
J. D. P. Roberts.
G. H. Smith.
G. J. Van Schalkwijk.
H. Van Zijl.
T. L. Winn.
F. Woodford.

Part II.

A. Bulleid.
M. Braun.
M. F. Braun.
H. A. Coysh.
C. D. M. Dorward.
L. W. Elmer.
C. Glassington.
H. Greaves.
L. Harley.
W. R. Hibbins.
C. F. Hudson.
H. A. F. Leipoldt.
J. Levy.
O. D. E. Morris.
O. G. Morris.
J. H. D. Myatt.
G. Parker.
B. M. Tonkin.
N. B. Wells.
T. D. Wille.
C. B. Wood.

Publications Received.

Hospital, Hospital Gazette, Architectural Association's Journal, Nursing Times, St. Bartholomew's Hospital Journal, St. Thomas's Hospital Gazette, University College Hospital Magazine, Ivory Cross Journal.

Guy's Hospital.

NOTICE.

Unveiling of the Guy's Hospital War Memorial by His Royal Highness The Prince of Wales, K.G. President of the Hospital, on July 15th, 1921

HIS ROYAL HIGHNESS THE PRINCE OF WALES, President of the Hospital, has graciously consented to unveil the War Memorial on Friday, July 15th, 1921, at 3.15 p.m.

Relatives of Guy's men who died in the War are invited to send their names to Professor Pembrey, Physiological Department, Guy's Hospital, who will forward tickets for the reserved enclosure.

Old Guy's men can obtain tickets for themselves and a friend on application to the Clerk of the Hospital, at the Counting House, and Guy's Students can obtain tickets for not more than two friends on application to the Librarian, Wills Library.

Junior Guyite Club.

The 35th Dinner of the Junior Guyite Club was held at the Restaurant Frascati on Thursday, June 16th. The following members were present:—

A. E. Price (President), S. E. Pratt (Vice-President), T. Brown, F. F. Burghard, H. H. Du Boulay, E. W. Goodall, J. A. J. Howell, T. D. Lister, Wm. Mollison, A. W. Ormond, M. Parry-Jones,, J. G. P. Phillips, C. E. Price, P. S. Price, P. N. Randall. R. M. H. Randall, A. R. Thompson, and J. A. Fraser (Hon. Sec.).

M. Coplans and J. A. Currie were present as guests.

The following members had accepted, but were prevented from attending:—H. E. Counsell, J. W. H. Eyre, H. French, and A. E. Kensay-Taylor.

The following members were duly elected:—H. W. Barber, M .Coplans, J. A. Currie, H. T. Depree, W. E. S. Digby, G. W. Goodhart, V. Glendining, N. E. Kemball, D. M. Lamore, V. E. Lloyd, G. Marshall, R. Montgomery, W. I. M. Reader, A. T. Rogers, F. D .Saner, W. J. D. Smythe.

The dinner for 1922 was fixed for the second Thursday in May, and the dinner provided at the Restaurant Frascati having met with the approval of those present, it was decided to secure the Alpha Salon again for the 1922 dinner. Dr. J. G. Phillips having offered to arrange for vocal and instrumental music (professional) at the 1922 dinner, his offer was gratefully accepted by the President on behalf of the Club.

Some Pulmonary Complications of Surgery.

CLINICAL LECTURE BY DR. RYLE.

GENTLEMEN,—Improvements in surgical technique and aseptic method, together with advances in anæsthesia, have steadily helped to eliminate the complications directly or indirectly attributable to operation in the surgical diseases, but we are still familiar with the fact that complications sometimes situated at a distance from the site of operation may and do occur, often giving cause for anxiety, and in some instances materially altering the prognosis and embarassing the post-operative care of cases.

I have chosen for discussion to-day the question of certain pulmonary complications of surgery, and in order to narrow my field propose to concentrate only on those which actually seem to follow operative interference, though they are not by any means necessarily attributable to the operative technique employed.

In cases of the type which I shall describe co-operation between the surgeon and physician may sometimes be of very real value; the elucidation of causal factors and explanation of end-results by the pathologist also plays an important part, and it goes without saying that it should be our aim by combined effort to eliminate so far as possible these distal complications as well as the more local ones which surgery has already been so successful in combating.

Those of you who become house-surgeons will certainly be confronted with cases which develop pulmonary symptoms or signs after operation, and in private too from time to time the convalescence, shall we say of some abdominal or obstetric case under your care, may be interrupted by troubles developing above the diaphragm.

It was in the hope of being able to help you to appreciate some of the more likely possibilities and to interest you in the diagnosis of these conditions that I made this my choice of subject, and consulted my case-notes.

The particular conditions to which I shall refer include Pulmonary Collapse and Compression, Pulmonary Abscess, and Pulmonary Embolism. Now excepting as incidental features of other diseases you will not find special mention of these conditions in your medical text-books; while being generally regarded as outside the province of the surgeon the surgical text-books are also reticent about them.

In respect of each one of them I want to try to consider with you some aspects of the diagnosis, prognosis, prophylaxis and treatment, and to illustrate my remarks by references to certain cases under the care of my surgical colleagues which it has been my good fortune to see during the past year.

With lobar pneumonia, broncho-pneumonia, and pulmonary hypostasis, all of which may of course follow surgical operation, I do not propose to deal; they may at times present problems in differential diagnosis, but are as a rule even more in the nature of accidental sequelæ than those complications I have named, and they do not differ in essentials from the same conditions as encountered in the medical wards.

Pulmonary Collapse occurring in a sufficient volume of lung to produce symptoms and signs is sometimes referred to as massive pulmonary collapse, in order to distinguish it from the more common scattered or patchy collapse such as is best seen at autopsy in the broncho-pneumonic lungs of children. Massive Collapse is a rare yet not a very rare sequela of operations not only on the chest but also on the abdomen, and though the mechanisms of its production are still under dispute, it has long been recognised as a clinical entity.

During the war massive collapse was frequently noted in the lung on the contra-lateral side to a chest-injury. This stimulated discussion as to the possibility of its being a reflex phenomenon dependent on diaphragmatic and intercostal inhibition. It most frequently occurred in the whole or part of a lower lobe, but sometimes in a whole lung. Operations in the upper abdomen, particularly when much handling is necessary, are perhaps the commonest precursors in civilian surgery. Theoretically pulmonary collapse may be produced either by blockage of a bronchus with subsequent absorbtion of air from the alveoli distal to the blockage, or by direct pressure on alveolar tissue by fluid or gaseous effusions or some solid structure.

In abdominal surgery the factors which would seem to contribute to its production are, firstly, bronchial obstruction dependent on

spasm and mucous exudate into the bronchi resulting from the anæsthetic; secondly, some interference with normal diaphragmatic movement reflexly or otherwise produced; and, thirdly, direct interference with respiratory movements of the chest-wall due to posture during or after the operation. There may, of course, in any individual case, be a combination of all three factors.

I think, perhaps, that I can best illustrate to you the symptoms and signs of massive pulmonary collapse by reference to two cases in which certain of these factors were apparently quite definitely present.

The first was that of a woman, under the care of Mr. Turner, who was operated on under intra-tracheal anæsthesia for removal of an adenoma of the thyroid.

The patient's condition was bad during the operation, and she did not come round properly from the anæsthetic for forty hours. There was considerable cyanosis for four or five days, and moderate sustained pyrexia for a week. She had a cough with slight expectoration but no hæmoptysis; she experienced some retro-sternal pain, but was at no period seriously distressed, nor did her appearance suggest much constitutional disturbance. The respiration-rate was never above thirty per minute. At the right base were definite signs including impaired resonance and tubular breathing, which suggested to her house-surgeon that she had pneumonia. However, the signs still persisted after subsidence of the temperature and the disappearance of cough. Four weeks after the operation I was asked to pronounce why the pneumonia had not resolved.

My notes state—"The patient looks well; shows no cyanosis or distress even on lifting herself in bed. The right chest does not move so freely as the left, and below the angle of the scapula there is definite slight flattening although circumferential measurement on the two sides shows no appreciable difference. The heart's impulse is not easily felt, and there is an impaired percussion note over the lower half of the sternum. There is a slight but definite impairment of percussion note below the angle of the right scapula and between the scapular margin and the spinal column; there is also a slight impairment of percussion note in the right axilla. Over the dull area behind there is tubular breathing, but complete absence of moist sounds. Voice conduction was ægophonic over the same area. Over the lowest limits entry is almost absent."

The history of cyanosis following a difficult intra-tracheal anæsthesia, the absence of constitutional disturbance, the flattening of the chest on the right, the slight traction to the right of heart and mediastinum, the broncophony with an ægophonic quality (a very characteristic sign in compressed lung), and the absence of moist sounds, together with the long persistence of signs, made massive pulmonary collapse an almost certain diagnosis, and explained the peculiarities in the post-operative behaviour of the case. Presumably the important elements here had been bronchial obstruction from spasm and irritation of the bronchial mucosa with some actual bronchitis following. You will remember that the right bronchus is more vertical than the left, and so more liable to trauma or irritation during the process of intra-tracheal anæsthesia. The operation itself probably played no part in the production of the collapse. The differential diagnosis was from pneumonia or effusion. The figure I have drawn on the board shows the area over which physical signs were noted. It corresponds closely with the surface marking of the right lower lobe, so perhaps we may assume that the lower branch of the hyparterial bronchus was occluded.

The second case was a man under the care of Sir Alfred Fripp, who was operated on for a perforated duodenal ulcer. The operation necessitated a good deal of manipulation in the upper abdomen. For the first few days after operation the patient's condition gave rise to some anxiety. The temperature, pulse and respiration rate all remained slightly raised. A dull area on percussion was found at the left base and—the possibility of a sub-phrenic abscess being entertained—the chest was needled in several places with a negative result.

My own notes state: "The patient does not look infected; tongue clean; abdomen satisfactory. There is no pain on pressure over the left lower ribs behind such as is often found in sub-phrenic abscess. There is flattening and impaired movement at the left base, with impaired percussion note, tubular breathing and absence of moist sounds. There had been no sputum. Diagnosis—massive collapse affecting left lower lobe."

The differential diagnosis here was between pneumonia, effusion or compression above a sub-phrenic abscess and simple massive collapse. The causal factors were probably the necessary manipulation in the upper abdomen, with some

eflex inhibition of the diaphragm. Whether posture and the anæsthetic may also have been contributory I cannot say.

In summary, then, we may find in massive collapse some initial dyspnœa and cyanosis, perhaps even with cough and slight pyrexia, but little or no constitutional disturbance such as is seen in a pneumonic infection, a flattened chest on the affected side, a tendency for the heart and mediastinum to shift to the affected side (just the opposite to what would be found with an effusion), impaired note but not complete dulness, bronchial breathing and bronchophony or ægophony, with finally an absence of moist sounds and a failure of the signs to clear as during the resolution of a pneumonia. Impaired or absent entry may precede the appearance of bronchial breathing.

X-ray examination in these cases shows in addition to opacity of the area of lung involved, a raised immobile diaphragm and an immobile chest-wall. Clinical and X-ray findings both suggest that fixation of chest and diaphragm, perhaps dependent on some reflex phenomenon, has occurred during an extreme expiratory phase, so that the alveoli have collapsed and have not become re-inflated.

The treatment of the condition consists in breathing exercises and free movement as soon as these can be permitted. If there is much cyanosis and dyspnœa in the early stages continuous oxygen may be given through a nasal catheter. The prognosis as a rule is very good.

The prevention, theoretically speaking, depends upon the avoidance of an irritating anæsthetic, of undue manipulation in the neighbourhood of the diaphragm, and of unsuitable postures which might hamper free respiratory movements during and after the operation.

The question of posture may, I think, be important. Massive collapse following chest wounds was apparently more common at the Base than in the Casulty Clearing Stations, and I have thought that this may have depended on the mechanical factors present during transport of the wounded by hospital train, when men lay for long hours on their backs or on the side contralateral to the wound. The fact that even buttock wounds sometimes showed massive collapse would seem to demand other explanations than that of reflex spasm. The complication appears to be less frequent than it actually is, both in war-time and civilian records, because it is so commonly diagnosed as pneumonia.

Pulmonary compression is, of course, the same in effect as collapse, and if the immobility of chest-wall and diaphragm is the important causal agent and not a secondary affair, compressed lung is possibly a more correct description than collapsed lung in many cases.

Undoubted compression of lung may occur above a sub-phrenic collection which is thrusting the diaphragm upwards, but, perhaps, also reflexly inhibiting its free movement, just in the same way as the movements of the abdominal wall are inhibited in the presence of peritonitis, or above some local inflammation. In such cases usually only a small portion of the lower lobe is flattened and airless, and except for an impaired entry and percussion note at the extreme base the physical signs may be inconspicuous.

I saw a case recently in which there was a sub-phrenic abscess on the right side producing slight compression of the right lower lobe later confirmed at autopsy. On the left side, too, there was some airless lung suggesting that the function of the whole diaphragm may have been impaired, and that the effect on the right side was not purely an upward pressure effect; undoubtedly, in cases which are seriously ill, we have also to consider the effect of posture and hampered respiratory movements, particularly in fat and helpless patients. In the case to which I refer, that of an obese elderly woman, there was gall-bladder pain and jaundice and great respiratory distress, which made us consider more seriously than we should have done the possibility of a dual pathology, that is to say, of a pneumonia complicating acute obstructive jaundice. I am now convinced that the severe respiratory distress was due to direct and, probably, also to some reflex inhibitory action on the diaphragm.

While considering the subject of subphrenic abscess it may be well to mention another intrathoracic complication of sub-phrenic infections. Pleurisy, with or without effusion, is a not infrequent accompaniment of subphrenic abscess, and its detection may sometimes be a valuable aid to the recognition of the mischief below the diaphragm. The effusion may be clear or purulent (or clear becoming purulent), and the needle should always be employed if there is any suspicion of a pleuritic effusion developing subsequently to a septic intraperitoneal operation.

So far we have been considering lung-changes which are in the main produced by mechanical factors, and in which the prognosis

is usually good for that reason. We have now to consider complications in which infection plays the more important part and in which the outlook is necessarily a much more serious one. Pulmonary abscess, you are probably aware, may, apart from direct trauma or invasion from other viscera, be produced in one of two ways. It either results from a metastatic or embolic process, in which case there are commonly multiple lesions (the most frequent instance of this type of infection is that seen in lateral sinus thrombosis following suppuration in the mastoid antrum), or it results from inhalation of a foreign particle or of septic material from the upper air passages. The latter event is clearly most liable to occur after operations about the throat or larynx, and is often accompanied by pulmonary gangrene, the two conditions not being easily separable clinically or pathologically.

In a recent analysis* by an American physician, Dr. F. T. Lord, of 100 cases of pulmonary abscess no fewer than 25 per cent. were shown to be traceable to an operation about the upper respiratory tract. In 12 cases it followed removal of tonsils or tonsils and adenoids, and in 9 the removal of teeth. Reference to the notes of cases will again perhaps give you the best idea of the clinical features which may be encountered. As an instance of the first or embolic group I may quote a case seen with Mr. T. B. Layton of a woman aged 30 who was operated on for an acute mastoid. A few days later her temperature soared and she had a rigor. I found a rub and impaired note at the right base, but, although alive to the possibilities I wrongly hesitated in making my diagnosis between a lobar pneumonia and a metastatic abscess due to sinus disease. The next day there was a small tender area about equal to a five shilling piece at the angle of the right scapula, over which percussion gave a "cracked pot" sound. I diagnosed a local abscess, needled and obtained pus. The abscess was drained, but as it was one of many and organisms were by that time freely circulating in the blood-stream the operation was of no avail. It is just conceivable that ligature of the jugular vein the moment the first respiratory symptoms were manifest might have saved life. There were two symptoms which should have impressed me more, and excluded an ordinary pneumonia from my mind. One was that the initial spike of temperature was above 105, the second that there was sweating instead of the customary hot dry skin of a pneumococcal pneumonia. Sweating and a "spikey" pyrexial curve are very constant features in pulmonary abscess whichever way it originates.

The first case in the second group followed a tonsillectomy and was fortunate in that spontaneous recovery occurred. Three days after the operation there was a sudden rise in temperature and pulse-rate and the respiration-rate reached 40. Severe pleuritic pain was felt at the angle of the left scapula, where a rub was heard, and there was a definite circumscribed area of impaired resonance. There was free perspiration on the next day, and a considerable amount of thick purulent sputum was expectorated with streaks of bright blood. For a day or two about 2 ozs. of pus was expectorated daily, and then recovery took place. Signs of a very small effusion developed at the left base, and the patient made an uneventful recovery.

It is possible of course that this case should be regarded as merely one of localised bronchopneumonia with pleurisy. The sputum did not become malodorous, and elastic fibres were not found—two final criteria of pulmonary abscess with destruction of lung substance—but the general history and clinical picture suggested much more, to my mind, a local interstitial lung infection which reached but did not pass the earliest phase of a lung abscess. It is of possible significance that the patient had for several weeks suffered from tonsillar sepsis and middle ear infection, and may consequently have developed an immunity which saved her lung from a worse invasion.

The next case was more lamentable. I was asked to see a man in the strong room who, shortly after an operation for gastro-jejunostomy on account of duodenal ulcer, attempted suicide. The wound which he had inflicted on his neck was unimportant, and his abdomen had healed well. He was, however, running a "spikey" septic chart, showed rapid respirations, was pale and sweating, and complained of pain under the right clavicle. He was spitting up whole cups full of foul, grey sputum, with the peculiarly disgusting odour which one associates with lung abscess and gangrene. He quickly developed a large blood-stained effusion on the right side from which no organisms were grown, but a few days later his lung abscess burst into the effusion, and he developed signs of a cavity at the right apex, that is to say in the exact region where he first complained of pain.

*Contributions to Medical and Biological Research, Vol. I., p. 640.

Amphoric sounds and the coin-test were both noted. An empyema drainage operation was performed, but the patient did not long survive it. A week or two later I saw a very similar case, also in the strong room, following an operation for perforated duodenal ulcer. At autopsy there was a large zone of diffluent necrotic lung in the left lower lobe, together with a right-sided bronchopneumonia and empyema.

Post-mortem notes of the case also stated, "There was an extremely bad condition of oral sepsis. The teeth were carious or broken, with many missing; the gums were recessive and unhealthly with much pyorrhœa. The left tonsil was black and 'sloughy.' The whole picture suggests that the lung condition was an inhalation infection." In the first case, too, there was grave oral sepsis, which through some oversight had not been dealt with before operation; the second case was an urgency, and there was no time for dental treatment.

Presumably in cases of this kind the diminished cough reflex during anæsthesia, the deep breathing and stertor during induction, the lowered resistance of the patient on account of his surgical disease, and possibly some local effect of the anæsthetic on the lung tissue or bronchioles as well, are the contributing factors which determine the development of an abscess after the inhalation of septic material. Sometimes a tooth or a small fragment of a tooth dislodged by the anæsthetist's gag has been inhaled and acted as the causative factor. In all but urgent cases pulmonary abscess should be and actually is a rare sequela of operation; but it goes without saying that a single case should serve to remind us of the importance of attending to oral sepsis in all cases on the waiting-list for operation. In throat operations in this country pulmonary abscess is a rare complication, and good anæsthesia and technique directed towards the removal of blood and fluids from the mouth during the operation should help to make it rarer still.

With regard to the treatment of pulmonary abscess one can only say that in a certain proportion spontaneous recovery occurs; in cases such as the two I have just described the progress of the disease is too rapid and the surrounding gangrene too extensive within a short period for one to hope for any results from surgical measures, while finally in the chronic circumscribed abscesses, when favourably situated, surgery may be clearly indicated, and in all cases open air treatment and improved nutrition are of the first importance.

In suspected cases the sputum should be examined for elastic fibres, and X-rays may be most useful in locating deep-seated abscesses.

I come finally to pulmonary embolism, which provides surgery with some of its saddest tragedies, because it comes so suddenly and unexpectedly, and not infrequently in the course of an apparently normal convalescence. Perhaps it has occurred most frequently after operations for appendicitis or pelvic operations. What presumably happens in these cases is that a thrombus formed in veins in the proximity of the appendix or tubes as the result of local trauma or some mild infection, becomes loosened and detached and is whisked to the right heart and so into the pulmonary artery, which it blocks.

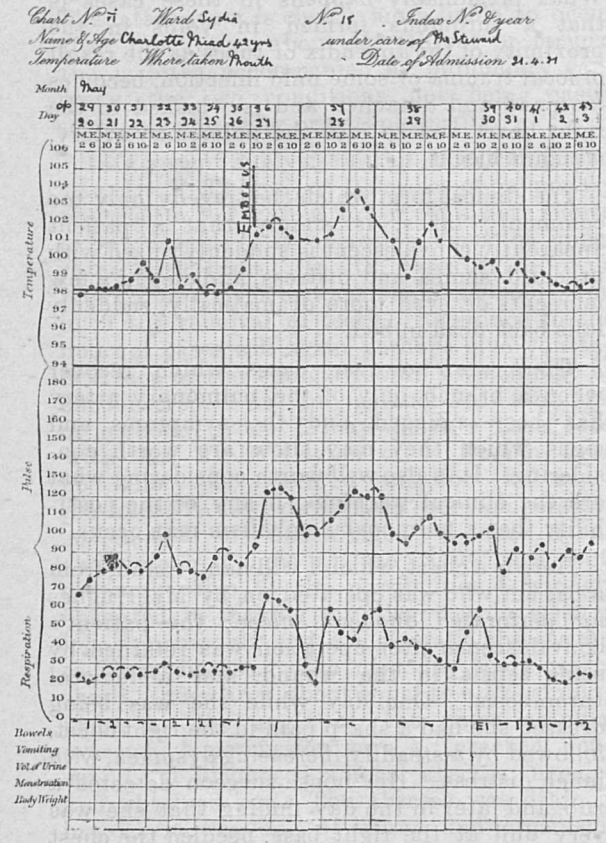
The clinical form which the tragedy only too commonly takes, is simply that a patient apparently convalescent is suddenly seized with urgent dyspnœa and distress, and dies in a few moments or, even more dramatically, suddenly falls back dead in bed.

There are, however, cases which recover when a branch only of the pulmonary artery has been plugged, and the symptoms and signs which they may show are worth considering. It is also well worth considering what are the clinical warnings, if any, of the possibility that a pulmonary embolism may occur.

Here is a chart, which I will hand round, from a patient who was operated on by Mr. Hughes for perforated duodenal ulcer; the patient's convalescence after operation was retarded by some sepsis in the wound, and a femoral thrombosis. One day while she was being dressed she had a sharp pain in the right chest, followed by a steadily increasing dyspnœa, with much distress. Her house-surgeon detected a rub, and later in the day finding that she was very dull at the right base, needled the chest for fluid, but with a negative result.

I saw her the same evening. Her respiration rate was 60, she was in great pain and her breathing was grunting in character, but she had no cough; the apex-beat was not displaced; there was dulness up to the mid-scapular region on the right side behind, and also in the right axilla just above the usual level of liver dulness. Bronchial breathing was heard close to the spine at the mid-scapular level.

The chest was firmly strapped with the result that the very severe pleuritic pain was immediately and thereafter completely controlled. I think that we are not sufficiently consistent in the application to painful chest conditions of those principles of physiological and mechanical rest which were enunciated so clearly in Hilton's classical book on "Rest and Pain"—a book of which I hope you will all obtain possession if it is not already in your libraries. Hot poultices and antiphlogistin are very useful and grateful to the patient, but "splinting" the chest with strapping may be even more



efficacious. Instructions were of course given to keep the patient as strictly at rest as possible. The temperature soon returned to normal, and she has remained fit up to the present, though after three weeks the signs still persist at the right base.

I think there can be little doubt that this was a case of pulmonary embolism from a clot in the femoral vein. There is one very instructive feature in the chart. You will notice that there was a sudden, slight recrudescence of pyrexia, after a considerable afebrile period, on the two days preceding the embolism. Does not this probably represent a loosening of clot and an invasion of the blood stream by toxic or infective material, and should we not be very wary in the presence of such unexplained pyrexial spikes after operation, particularly when we know or suspect that there is a likelihood of local thrombosis in a pelvic or femoral vein? All pyrexial spikes must have an explanation, and with a warning signal of that kind it is possible that we might occasionally avert a tragedy by giving very strict instructions as to the immobilization of the patient.

I will describe only one more case to you, partly to set you a problem in diagnosis, and partly to illustrate a very useful adjunct to the treatment of urgent cyanotic dyspnœa.

A girl of seventeen had acute appendicitis but was not operated on for a day or two. She took the anæsthetic rather badly, but the operation was satisfactorily performed. Soon after her return to bed her pulse, temperature and respiration started to mount, and she became very seriously ill with dyspnœa, polypnœa, and blue-grey cyanosis. When I saw her her respiration rate was 70, her pulse 180, and her temperature about 103. There was "board" dullness at the right base behind but no shifting of the heart, and no appreciable flattening of the chest wall; air-entry was almost absent over the whole right lower lobe.

She was very ill, and I thought it most unlikely that she would recover, but advised that oxygen should be given continuously into the naso-pharynx by a No. 8 soft rubber catheter passed back to a distance of four inches along the floor of the nose.

This was a method improvised for the treatment of gassed cases in France, and repeatedly and very successfully employed. With the exception of the oxygen chamber it is the most efficient method of oxygen administration I know, and I regard it as superior in many ways to the Haldane apparatus, although more wasteful in oxygen. After the lecture I will demonstrate the simplicity of the method to you.

In the case of this girl oxygen was given for 48 hours continuously, by which time she was obviously out of danger, pulse and respiration rate having steadily fallen; a healthy colour had replaced the cyanosis. Her temperature descended by lysis, she had no sputum and no

moist sounds. On the second day high-pitched breathing was heard instead of the impaired entry. She did not appear toxæmic.

The signs persisted almost unchanged until her discharge some weeks later. Repeated needling failed to reveal the presence of fluid. X-ray examination confirmed the clinical finding that there was no shifting to right or left of the heart and mediastinum.

I do not think she had pneumonia. Was she an embolism or a massive collapse? It is, I think, unusual for embolism to follow operation so quickly; on the other hand, the signs of collapse as I have described them were not all in evidence, and the degree of her cyanosis and her very grave symptoms were rather reminiscent of the effects which result from embolism. Yesterday I sent for this patient to come to my Out-Patients. She has now no symptoms or abnormal physical signs two months after the event, and this, I think, favours the collapse theory.

I hope that I have not been too tedious in recounting this small series of cases. If they have helped you to realise that the pre-operative and post-operative care of your patients, and close observation of their symptoms and their charts may sometimes be of as great importance as the operation itself; if they have interested you in the differential diagnosis of intra-thoracic lesions—always a fascinating problem—and, if finally, they have served to remind you that simple physiological, mechanical and hygienic principles may be of real value in the avoidance and the treatment of certain pulmonary complications, then my case-notes and recollections will have been instructfve to you as well as to me.

Change of Address.

B. M. Tonkin, M.R.C.S., L.R.C.P., L.D.S., Trewidden, Graytown, Natal, S.A.

Appointments.

Montagu F. Hopson, Examiner Entrance Examination, Royal Naval Dental Service. President Section of Odontology, Royal Society of Medicine.

Papers by Guy's Men.

W. H. Ogilvie, M.A., M.Ch., F.R.C.S., and A. W Hall. The Treatment of Cutaneous Anthrax.—*British Medical Journal*.—June 18th, 1921, p. 889.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

Photograph of Clinical Wards: Miss Strick's View.

DEAR MR. EDITOR,—It is interesting that there should be any doubt as to the identity of the four Clinicals. Dr. Munden is to my mind quite right in every case, and Dr. Clarke dates the photos several years too far back by his group. Dr. Carlill places Drs. Harrison and Hamilton correctly. E. Bellingham Smith is in Wimpole Street and Dr. H. S. Knight in Brockley.

I was surprised to see no mention in your obituary notice of Dr. A. S. Taylor of his prowess as the English Rugger full back, it is sad that it should fall to a Thomas's man to draw attention to it; perhaps one of his contemporaries may be stimulated by this note to write something about him.

Apart from his personal charm I always enjoyed meeting him, most often at the Surbiton Cottage Hospital, because he was so good to look at; he was one of the best built and handsomest men I have seen.—Yours,

C. H. FAGGE.

3, Devonshire Place,
Portland Place, W.
June 11th, 1921.

Remuneration of Out-Patient Officers.

DEAR MR. EDITOR,—The regulation with reference to Out-Patient Officers has been adopted in view of the fact that these gentlemen have no night duties, and therefore residence is not really necessary for them. At the same time the Governors feel that an allowance in lieu of board and lodging may help to render this appointment not less popular and not more expensive than the appointment of Assistant House-Surgeon,—With kindest regards. Yours sincerely,

HERBERT L. EASON.
Guy's Hospital, S.E.1. Superintendent.
June 20th, 1921.

NOTICE.

The Court of Committees has decided that in future Out-Patient Officers will not be provided with board and lodging in the College, but that they will be granted an allowance in lieu thereof, amounting to £3 per week for the period of their appointment.

By Order of the House-Committee.
June 21st, 1921.

Some Points about General Practice.

BY DR. SEYMOUR PRICE.

Gentlemen,—

I must preface my talk with you on "Some Points about General Practice," with two explanations by way of excuse. First, as some of you know, this lecture is the outcome of a correspondence in the GAZETTE entitled "The Business Side of General Practice." When I was invited to speak to you I said at once that it would be far better to get a man with a much wider experience as a G.P. Still, remembering that everything must have a beginning, and deeply sensible of the honour in being asked to come back here and address you, I hope that if I make the best attempt of which I am capable some much more able G.P. will be found for a future occasion.

Secondly, a lecture of this kind is bound to be largely founded on one's own experience and the opinions one deduces therefrom. I may therefore make many observations which will not coincide with other folks' opinions. Remembering the old tag "Quot homines, tot sententiæ" and that every man is entitled to his own opinion, I will ask you to bear with me. I have no cases to show you, no bottles (sealed bottles, gentlemen!) to pass round, no blackboards covered with statistics, and I cannot even draw. Before we come to the actual question of General Practice let me urge you after you leave here and before you settle down to travel abroad. I beg you to do this for three reasons.

1. After five years or more of close study and work, plus the worry and anxieties of examinations, to which has been added in many cases the responsibility of house appointments, you need a real change. You may find that this is the only chance in your life for such a change.

2. That you may see how it fares with your professional brethren in other lands. See their hospitals, watch their methods. You will be amazed at the warmth and sincerity of the welcome they will give you.

When I went to Boston, Mass., I had two introductions to medical men given me by Dr. Wilfred Grenfeld of Labrador fame, who had stayed with me and helped me with invaluable advice in running a hospital in Newfoundland through an outbreak of typhoid fever. I only needed one introduction. When I called on Dr. Robert Osgood (who was then doing his famous work on Poliomyelitis) he asked me to dine at his club that evening and he invited about a dozen colleagues to meet me. After that I never had a dull moment, they vied with each other in showing me everything in their great city from Harvard University and the Massachusetts General Hospital to a wonderful private nursing home at Corry Hill—the like of which this country does not possess. I mention this merely to show the kindness and hospitality one gets and for which one is so grateful when travelling abroad. I had similar experiences in Montreal, New York and Paris.

3. Travel—to use an Americanism—"opens your head," it broadens your sympathies, enlarges your outlook on life, but, above all, it helps to dispel that narrow spirit of insularity, that intolerant attitude of mind which brooks no regard for anything outside your own school or your own country.

Listen to what that great master the late Sir William Osler says on this matter. "At a tender age, four or five years give a man a local attachment to place and teachers which is very natural, very nice, but not always the best thing for him. He goes out with a strong bias already in him and is ready to cry 'I am of Guy's,' 'I am of Bart.'s,' or 'I am an Edinburgh man.' To escape these trammmels, which may badly handicap a man by giving him an arrogant sense of superiority often most manifest when there is least warrant, is very difficult."

He goes on to cite the case of three brothers, Edinburgh men, who entertained a supreme and ludicrous contempt for men of all other schools, though a Guy's man, they said, they could just tolerate for the sake of Bright, Astley Cooper and Addison. Do not expect a highly-paid post whilst travelling. The only investment you can afford to make at present is in Grey Cortex, so be content if you secure a billet that will provide the bare necessities of life.

With your wander-year completed you will now be on the look out for a partnership or practice.

As regards partnership—this is a most serious matter. Partnership is in many respects like marriage and therefore "not to be taken in hand unadvisedly, lightly or wantonly." If you are lucky enough to find a man wanting a partner with whom, after due trial and strict examination, you feel you could work in loyal harmony, and if he feels the same about you, then you may safely join him.

One has seen many partnerships that are unhappy often from lack of consideration of brotherliness on the part of the senior partner and still more often from lack of humility and loyalty on the part of the new comer, who has expected at once to take a full share in seeing the older and (forgive the phrase) more important patients. He has failed to recognise the obligations of a junior partner.

If you buy a partnership with a view to succession remember two points. One: No doctor has any proprietary right over any patient—a point that is often lost sight of. If you think for a moment you will realise that every patient is free to change his or her doctor at will. The late Sir James Goodhart was very emphatic on this point. Two: The value of the practice to you is in direct proportion to the length of introduction. The longer the out-going partner stays the better chance will the patients have to estimate, not only your professional skill, but also your charm of manner. In London I doubt if any practice is worth a year's purchase unless there are valuable appointments which are transferable. This point was made evident during the War when despite hurried and futile efforts in 1914 to make some arrangements with neighbouring doctors for carrying on one's practice, one found on returning after nearly five years that patients had wandered off here, there and everywhere. One had, however, the amazing good fortune to get more than nine-tenths of them back when one got home. The disappointing thing was this, no effort was made by other doctors in one's absence to find out from patients who their ordinary doctor was, and so a practice that had more than sufficed to keep a wife and family until 1914, during the War brought in only 14 guineas a year for each year of service and the larger part of this modest sum required a great deal of tactful persuasion to get.

If you are likely to practise in the country you will be wise to do a course of dental extractions. In the only "locum" I ever did I felt the need of this acutely. A burly man arrived at the surgery one evening with an aching molar. I advised him that the tooth could be saved if only he would wait until he could go into a neighbouring city to a dentist. Not a bit of it, he wanted it out then and there. After some search, I found a case of dental forceps, picked out what I prayed might be a suitable pair, placed the poor patient in a chair and tried to remember how the dentist had stood when he did the like by me. I got hold of that tooth and pulled and pushed and wriggled it and nothing happened, except that the man groaned horribly. I then gave him a breather and went at it again. Wonderful to tell, the tooth came out, and, moreover, by pure luck it came out whole. As soon as we had both recovered from the shock, the patient said he had never had a tooth drawn so well. I think he must have possessed all his other teeth intact. At any rate that tooth occupies a place in my mental museum next to my first salmon and my first pheasant. Now, what are some of the factors that make for success in General Practice? First and foremost one must put tact. You may have the highest professional attainments and skill; you may have all the gold medals, diplomas and certificates that can possibly be gained; you may be industrious, in short, you may be possessed of every moral and social virtue, but if you have not tact, if you cannot handle a difficult and delicate situation without hurt to any party concerned; if, in fact, you cannot avoid treading on other people's corns you will not succeed. Truly an ounce of tact is worth a pound of knowledge, for "knowledge comes, but wisdom lingers."

Second come Method and Routine.

If you conduct your practice on sound methodical lines with a routine that is sufficiently elastic to allow of necessary daily alteration, you will get through far more work with far less worry and fatigue than the man who does all his work in a haphazard and slipshod way. Keep up the method of case-taking you have learned here with the use of all the instruments of precision. Examine fully and make notes of every case that comes into your consulting-room. You will be surprised how often a patient, whose only complaint is a simple ailment (which carries with it such a temptation to treat subjective symptoms on the penny-in the-slot principle), will, on careful examination,

reveal a diseased spot of which he or she is entirely ignorant.

I remember a case coming to me which had been under the care of two doctors for nine months. The first doctor had diagnosed indigestion and had failed to cure her, the second suggested a sluggish liver and he too was unsuccessful, but, mark this, beyond looking at her tongue, neither had examined her. She had malignant of the right kidney almost as big as your head which no one could have missed had she only been examined. Again, you may not see a patient for years and no feat of memory will enable you to recall, say, their blood pressure or their weight. Yet, on their return, you have all your notes of the case to hand much to their joy and your own relief. Keep a slip of paper in your pocket and jot down things you want to do just and when they occur to you, letters to write, etc.—it saves an enormous amount of worry, prevents omissions and gives your memory a chance to record important facts without having to worry about minute and trifling details. The third factor is Enthusiasm. This will enable you to surmount all obstacles. Nothing but the best will do for your patients—the best treatment that can be devised, no stone left unturned to secure their comfort. This factor alone will carry you through those tragedies of life at which we are always present by reason of our calling—"a profession that demands greater sacrifices than any other." No room here for boredom and no time to become blasé. Will you allow me to say a word about the patient whose end is near? Has not he or she the right to be told gently and tactfully that you think the Great Adventure may soon take place? If we withhold this knowledge, surely we are taking a big responsibility on ourselves. Has not the priest of the soul as much right to be present, if wished for, as the priest of the body?

In this, as in everything, we must pay due and full regard to the wishes of the patients and relatives.

The fourth factor is sympathy—not weak, maudlin sentiment, but the ability to put yourself in the patients' place, so that you may realise in some degree the pain they are suffering, the depression that is weighing them down, and the apprehension that assails them. It is this factor that enables one to comprehend the mental attitude of one's patients. The comparatively simple pain that would cause but little distress to the strong-minded may, in the highly-strung, become magnified into a real agony. An unsympathetic mind may fail to grasp the position and so may fail to help or even cheer the patient. A world of truth lies in the old proverb "a fellow-feeling makes us wondrous kind."

Next, have only one class of patients: *sick folk*. Disease recognises no social or class distinctions, nor must we. The between-maid is just as much entitled to our best skill and sympathy as the duchess; nay, more so, for the former has often no choice of doctor, whereas the haughty dowager will not fail to turn us down if she so pleases. One often sees undue regard paid to wealth and position. There is no more room in the profession for the snob than there is for the cynic. I know of a doctor who is a shrewd observer, capable and painstaking, and yet he is a failure. Why? Because at the end of an interview he cannot refrain from a touch of cynicism and will say, "Well, here is a prescription for you, you can try it, but I don't suppose it will do you any good."

Now about fees. Please remember the excuse I made at the beginning. I am only expressing my own opinion, and opinions differ. It has always appeared to me that our profession is grossly underpaid. Take, for example, a wealthy man who requires an operation on which his very life depends. He would be shocked at being charged, say, five hundred guineas, and yet that same man will part with five thousand guineas in litigation where only his good name and not his life is at stake. We have always been at fault in being willing to carry out our professional work at low figures, and considering the time we often have to wait for our money it is not a proposition that would commend itself to any business man. The late Canon Rhodes-Bristowe gave me a piece of good advice whilst I was a student. He said, "Doctors make a very great mistake in only sending out their accounts yearly or even half yearly. No patient likes to get his doctor's bill long after the illness is over and forgotten." I have always acted on that advice, for I think it is sound and reasonable.

The father of the most brilliant Guy's man of my time, now also dead, gave me this maxim: "Never leave a patient without feeling that you have earned the fee you propose to charge. You may not earn it by your prescription, but you should feel you have earned

it in some way by advice, by sympathy, or by help."

I found long ago that reducing one's fees to certain patients was unsatisfactory in every case, so my rule now is a reasonable fee or nothing.

Whilst on the question of finance, one more piece of advice is, I think, worth handing to you. It was given me by a patient who, in spite of delicate health, has climbed to the very top of his profession. He said: "The man who starts out merely with the idea of making money will never meet with the same success as the man who sets out to do his job to the utmost of his ability. Never worry about making money, for if you do your work really well you will find that all the money you need, and possibly more, will come as a result."

Next, the question of calling in a second opinion, always a difficult point. It seems to me that strict honesty with oneself is the only criterion. What is best for the patient? This must be your guiding principle.

When in doubt about a case, candidly ask the patient or the relatives if they would wish for another opinion, and freely admit that you yourself would be glad to have one. Leave the choice of that second opinion to them. If they know of no one you can give them several names to choose from. Naturally, before the arrival of the consultant you will long ago have carried out every reasonable investigation. You do not want to get "your eye wiped," by the consultant finding a urine loaded with albumen, a choked disc or an absent knee jerk. This has happened before now.

Consultants vary as much as G.P.'s. A well-known patient has laughingly threatened to write a book entitled "Monsters of the Medical Deep," and has done me the honour of promising me a chapter all to myself!

Most consultants I have had the pleasure of meeting play the game. They treat one with every courtesy and consideration, are loyal and helpful. To them one owes a debt of gatitude one can never repay. One or two will tire the sick patient dreadfully by examining them from top to toe and taking over an hour to do so. Some, after a casual glance at the patient and a few well-chosen words, on withdrawing, say, "Quite all right, old man, nothing to add to diagnosis or treatment unless you care to try 'Beatemall'"—some new preparation advertised in the medical papers.

One consultant, arriving half an hour late for the appointment, proceeded to catechise me as follows:—"I suppose you never thought of examining the urine." On being informed that his supposition was incorrect, he went on, "Has it occurred to you to examine the eyes?" This, too, had been done, and so on through the whole gamut of stock questions. Finally, having thrown no fresh light on the case and given me no help, he remarked as we were leaving, "These are very important people, I wonder how you came to look after them." I have never found the necessity for calling in that gentleman again.

A word about diet. It is not enough to generalise on the matter of a patient's food. One should always go carefully into the whole list of dishes available so that there may be as wide a choice as is compatible with the patient's condition. The day has long gone by when the matter can be dismissed by airily saying, "a glass of sound wine, the wing of a bird, and a little carriage exercise."

A small detail. Don't order your patient a boiled sole. Try it yourself first. It is said that eating a boiled sole is like kissing your own sister. In general you will find that pills, powders and potions form but a small part of your therapeutic equipment and it is quite right that this should be so. Preventive measures, vaccines, diet, exercise, massage and baths play an increasingly large role in successful treatment. Keep abreast of the times by reading not only the medical papers, but also books and monographs. For the sum of thirty-five shillings a year you can now get three books at a time, which you can change as often as you wish—the latest books on every branch of our craft, so there can be no excuse for getting rusty. The busiest day will probably still leave you time for a pipe and a book before turning in.

What of Medical Etiquette, of which the public talk so much that one would think it must be as big as the Napoleonic Code? Surely it can all be summed up in two words: "Play the Game," a lesson Guy's has taught us from the first, and "Do unto others as you would they should do unto you."

Never listen to tales, tittle-tattle or scandal about a brother practitioner. Your female patients will sometimes try to tell you how

Dr. X. has bungled their case and how Dr. Y. has never understood them. Remember they will probably be saying the same thing about you in a short time. You will be the Dr. Z. Many a doctor is talked into and out of practice by what used to be called the gentle sex. In this respect our greatest friends may also be our greatest enemies.

Let me suggest that you should have some special hobby in your professional work. Do not misunderstand me. I am not for a moment suggesting that you should attempt to be specialists. I remember the late senior surgeon of this hospital remarking that it seemed to him that a specialist was a man who had developed special sense to the exclusion of all common sense.

You will remember the story of the two American surgeons who met at dinner and were at daggers drawn because each was a nose specialist, and how their jealousy was set at rest by the discovery that one specialised on the left nostril only and the other on the right. What I mean is this, you will find it adds considerable interest to your general work if you take up some particular line and make a specialty of it.

Remember Sir James Mackenzie made his reputation as a cardiologist while still a busy G.P. in Lancashire. There are still many diseases whose cause is obscure and treatment consequently largely empirical. If you select one of these, make a special study of all the literature and then start out to work at it yourself, you will be surprised how soon you begin to get a group of cases suffering from such a malady.

Since the war I have been working at the so-called Rheumatoid Arthritis, and I already have a group of seventeen cases. It seems to me that the lack of some special interest of this kind may be the cause of this apathy of many doctors. Amongst the numbers one met on active service, it was depressing to learn how many disliked their professional civil work. At the same time one could not fail to notice that the routine and discipline of army life seemed equally distasteful to them.

This rather gloomy picture was relieved by other medical men who were full of enthusiasm. I remember one who took a series of air-flights including "stunt" flying, in order to record the effects on his own blood-pressure. He frankly admitted in the paper he published that his findings were probably vitiated by the fact that he had "wind up" the whole time he was in the air. Without enthusiasm and without any attempt to add to our wonderful heritage, made wonderful by no efforts on our own part, but by the unstinted labours of those who have gone before us, I am free to admit that general practice may prove a weariness to the flesh.

Lastly, have some hobby or pursuit entirely unconnected with your professional work. It takes your mind off worrying cases and brings you back fresh into harness again. Something that will give you exercise in the open air, such as golf or gardening, if you can manage it. If, however, your lot is cast in a big city with no garden and no time for games you may still get exercise and relaxation by hunting the elusive antique. I plead guilty of spending many happy hours with my wife in this fascinating, if urban, form of hunting. Follow your hobby with the same zest and keen enjoyment that you put into your practice.

Let me close by once more quoting Osler: "The cultivated general practitioner. May this be the destiny of a large majority of you! Have no higher ambition! You cannot reach any better position in the community. The family doctor is the man behind the gun who does our effective work. That his life is hard and exacting, that he is underpaid and overworked, that he has but little time for study and less for recreation—these are the blows that may give finer temper to his steel and bring out the nobler elements in his character."

Notices.

Royal Naval Dental Service.

The Examination of Candidates for Entry into the Royal Naval Dental Service will be held at the Royal Dental Hospital of London, Leicester Square, W.C. 2, on the 20th July, and following days. The number of appointments to be offered for competition is 9. The Regulations for Entry and the form to be filled up by Candidates will be supplied on application to the Medical Director-General, 1, Lake Buildings, St. James's Park, London, S.W.1. The form accompanied by the necessary documents should be returned not later than the 8th July.

The Hospital "Blues."

The following have been awarded "Blues" or "Half Blues," as indicated, up to April, 1921.

RUGBY.

Blues.—C. L. Steyn, E. E. Neser, H. Van Zijl, A. Daneel, P. K. Albertijn, W. H. Taylor, R. F. H. Duncan.

Half Blues.—F. J. Biddle, R. R. Macintosh, S. P. Meacock, E. L. Sprong, H. Van Heerden, L. B. Helder, P. Harvey.

ASSOCIATION.

Blues.—E. Hardy, L. S. Williams.
Half Blues.—V. R. Morgan, O. F. Painter.

HOCKEY.

Blues.—L. E. Owen, W. S. Hunt, F. E. Graham-Bonnalie.
Half Blues.—C. V. Baugh, H. Slater, K. Hooper.

ATHLETIC (Cross Country).

Half Blues.—L. G. Housden, R. S. Chambers, M. E. M. Jago.

BOXING (Pavy Gymnasium).

Half Blues.—J. A. F. Denyssen, T. A. Shaw. W. H. Summerskill.

RIFLE.

Half Blues.—G. W. Elkington, J. V. Bingay, G. Beamish, E. A. Lloyd, M. Weinbren, W. H. Foy.

GOLF.

Half Blues.—A. C. M. Coxon, G. M. Stuart, F. W. Stiven, K. F. McAlpine.

The above should apply at the Medical School Office for an "order" on Lewin any day before 1.0 p.m.

L. B. HELDER.
Hon. Sec. "Blues" Committee.

Reviews.

Thyrea and Other Sonnets. By John Ferguson. Seventh edition. (Messrs. Andrew Melrose, Ltd.) Price 1s.

One turns with pleasure from the task, occasionally wearisome, of reviewing large text-books to a perusal of this collection.

One does not need to be a critic of poetry pure and simple to appreciate this work. Upon the technical aspects of a poet's art we will not dwell in writing this review. It is sufficient to say that we feel the human interest of these verses. "One touch of nature makes the whole world kin," and it is in recording the ordinary emotions and experiences of life with accuracy and sympathy that the poet reaches the ordinary mortal's interest.

Mr. Ferguson has succeeded in doing this But we cannot admire all the poems equally. Occasionally the pathos of the "Thyrea" sequence is laboured. Sonnet No. III. is not up to the general standard of the book. The sixth sonnet appeals to us more than the others.

As regards the "Other Sonnets," they seem to us better than "Thyrea." "The Abbey Ruins" in particular reaches a high standard of delicacy of tone and beauty of language.

Like Mr. Courtney, who wrote the introduction to the second edition, we appreciate Mr. Ferguson when he writes about solemn themes, as in "Beethoven," or "Chopin's Marche Funebre," but we cannot wholeheartedly praise his sad descriptions of sanatorium life. In short, these poems are valuable for their concise yet beautiful descriptions of the events of everyday life.

Abstracts of Current Medical Literature.

Radium Therapy in Uterine Cancer. (*B.M.J.*, June 18th, 1921, p. 881.)

Hayward Pinch discusses the use of radium in uterine cancer, with special reference to technique in various types of the disease. He also discusses it in relation to surgical measures, and advocates operation in all operable cases, preceded and followed by prophylactic irradiation.

Treatment of Acute Pyogenic Infection of the Knee-Joint. (*Ibid.*, p. 884.)

A. H. Southam describes four cases of infection of the knee-joint, and draws the conclusions that the insertion of drainage tubes is harmful in acute arthritis. He recommends thorough irrigation while extension is applied to the limb. Mobilisation and massage must be instituted as soon as active inflammation has subsided.

Results of 98 Cases of Nerve Suture. (*Ibid.*, p. 885.)

The original observations of P. C. Dane (Med. Jour. of Australia, July, 1921) have been amplified by the addition of new cases. The author discusses operative treatment, and emphasises the importance of rest, effectual splinting, and gradual re-education after operation.

Five Cases of Rat-bite Fever. (*Ibid.*, p. 886.)

F. W. Burton-Fanning discusses the ætiology of this remarkable disease, and describes five cases seen since 1897, the last being in 1921. All five cases eventually recovered. Quinine was found to be useless. Two cases were treated successfully by novarsenobillon.

The Treatment of Cutaneous Anthrax. (*Ibid.*, p. 889.)

W. H. Ogilvie and A. H. Hall compare the results obtained by serum treatment, and reported in Circular 172 issued by the Ministry of Health (January 28th, 1921), with those obtained by a combination of excision and serum treatment at Guy's Hospital

between 1909 and 1919. They conclude that the latter is more efficacious than either method used alone.

Surgery of Lung and Pleura.

(Lectures delivered by G. E. Gask at the Medical Society of London on February 7th and 21st, 1921.)

Lecture II. (*Lancet*, June 11th, 1921) deals with the treatment of wounds of the thorax during the war, and discusses the mortality, pathology and channels of infection in chest wounds. The author considers that the obstacles to chest surgery are not so large as was once supposed, since one pleural cavity may be opened under a general anæsthetic without any grave danger. Operative treatment is fully discussed. The lecture is well illustrated, the illustrations including three excellent coloured plates.

In Lecture III. (June 18th, 1921) the author discusses the present position of surgery with reference to diseases of the thorax, and deals with the application of war-time experience to methods of diagnosis, of opening the chest, treatment of empyæmia, etc. He shows that the old-time dread of opening the chest was overcome during the war. Surgeons learnt to open the thorax and repair a wounded lung.

The operation of thoracotomy should, he considers, become as useful and ordinary as that of laparotomy.

Relation of Heart Disease and Pregnancy. (Section II.—*Lancet*, June 11th, 1921. Section III.—*Lancet*, June 18th, 1921.)

In Section II. Sir J. Mackenzie discusses the relation of the physiology of the heart to its efficiency and the mechanism of heart failure. He concludes that the left ventricle does not hypertrophy during pregnancy. The mechanism by which pain is produced is referred to: the author shows that cardiac distress may produce a cessation of effort and thus act as a protective measure.

In Section III. the significance of murmurs is discussed. He concludes that one can permit pregnancy in cases of aortic regurgitation, if there is no "Corrigan" pulse and if the response to effort is good.

Hypo- and Hypo-Thyroidism. Causation. Prevention, and Treatment. (*The Practitioner*, June, 1921.)

Sir James Barr distinguishes between diseases due to hyper- and hypo-thyroidism. In exophthalmic goitre the author recommends treatment by concussion on the cervical spines with a plexor and plexi-meter. As an auxiliary measure a large dose of chalk with bicarbonates, followed by olive oil, should be given at bedtime. The author having seen many deaths from thyroidectomy, refuses to be *particeps criminis*.

In hypothyroidism, iodine is our sheet-anchor. The author considers enlarged prostate to be due to defective functioning of the thyroid.

Surgical Treatment of Chronic Intestinal Stasis. (*Medical Science*, June, 1921, p. 221.)

The prolonged study of cases before operation is advocated It is suggested that a minute study of the histology of colons excised might show that in these cases there is some disturbance of the neuro-muscular mechanism. The relative value of partial and total colectomy is discussed and preservation of the ileocolic valve, hitherto usually sacrificed, is advocated whichever operation be performed.

Typhus. (*Ibid.*, p. 191.)

This article reviews the literature of the Serbian epidemic of 1915 and of the various epidemics among prisoners of war in Poland and Russia from 1915—19. Stress is laid on the importance of recognising the disease clinically before the Weil-Felix reaction has made its appearance. Prophylaxis is directed toward killing ova of lice in infected clothes. Zielinski, of Warsaw, advocates the use of subcutaneous injections of the patient's own cerebro-spinal fluid. This method of treatment halved the mortality among severe cases.

Whooping Cough. (*Ibid.*, p. 201.)

Several new methods of treatment are described and discussed, notably the injection of ether intramuscularly, the administration of benzyl benzoate, and the use of diathermy. A vaccine has also been prepared both for prophylactic and curative use. Vaccine therapy, to be successful, should be begun within eighteen days of the onset of the disease and before typical paroxysms have developed.

The Hospital Athletic Sports,

These were held at Honor Oak Park on Wednesday, June 15th, the hottest day for five years (see *Daily Mail*). Over five hundred people were present, including many members of the Staff. The standard of racing was high, four Hospital records being broken, three by Steyn and one by Gough. Enthusiasm, always high among the competitors, reached a climax in the mile handicap, when Jago, having won comfortably from his mark of 300 yards, completed another three-quarters of a lap before he could be prevailed upon to stop. The tug-of-war final was perhaps the most exciting event, the "Wards" team holding their own with a very much heavier "Dental" team, and only losing by the odd pull. As usual there was no lack of entries for the "Scurry Stakes," the final being won by Sprong after a determined but erratic race. An innovation was the band race, won by the cornet, after the disqualification for running of the double bass. At the conclusion of the afternoon, the prizes were distributed by Mrs. Rowlands, to whom a bouquet was presented by Miss Mutch. Dr. Fawcett, in a short speech, expressed his pleasure at the success of the afternoon and called for three cheers for Mrs. Rowlands, one of the Hospital's most ardent supporters in all kinds of sport.

Results—

100 *Yards Scratch.*—C. L. Steyn, 1; P. K. Albertijn, 2. Time, 10 2-5 secs. Won by 2 yards.

100 *Yards Handicap.*—H. Slater (8½yds.), 1; C. L. Steyn (scr.), 2; W. Leslie (8 yds.), 3. Time, 10 3-5 secs. Won by a foot.

220 *Yards Scratch.*—C. L. Steyn, 1; P. K. Albertijn, 2. Time, 22 4-5 secs. Won by 5 yards. Hospital record.

220 *Yards Handicap.*—E. E. Neser (16yds.), 1; A. S. Gough (15 yds.), 2; W. G. Sears (17 yds.), 3. Time, 22 4-5 secs. Won by 1 yard.

440 *Yards Scratch.*—C. L. Steyn, 1; P. K. Albertijn, 2. Time 53 1-5 secs. Won by 8 yards. Hospital record.

440 *Yards Handicap.*—C. L. Steyn (scr.), 1; L. P. Tupling (14 yds.), 2; J. P. Hartman, (30 yds.), 3. Time, 53 4-5 secs. Won by 5 yards.

880 *Yards Scratch.*—A. S. Gough, 1; J. D. S. Thomas, 2. Time, 2 mins. 10 2-5 secs. Won by 10 yards. Hospital record.

880 *Yards Handicap.*—J. C. Faull (50 yds.), 1; J. D. S. Thomas (35 yds.), 2; J. P. Hartman (50 yds.), 3. Time, 2 min. 3 2-5 secs. Won by 8 yards.

One Mile Scratch.—J. C. Faull, 1; L. G. Housden, 2. Time, 5 min. 1 sec. Won by 10 yards.

One Mile Handicap.—M. E. M. Jago (300 yds.), 1; J. P. Hartman (350 yds.), 2; J. D. S. Thomas (250 yds.), 3. Time, 4 mins. 10 1-5 secs. Won by 20 yards.

Three Miles Scratch.—L. G. Housden, 1; R. S. Chambers, 2. Time, 16 mins. 3 2-5 secs. Won by 350 yards.

Three Miles Handicap.—M. E. M. Jago (1½mins.), 15 mins. 47 secs., 1; R. S. Chambers (70 secs.), 15 mins. 57 2-5 secs., 2; L. G. Housden (scratch), 16 mins. 3 2-5 secs., 3.

120 *Yards Hurdles Scratch.*—P. K. Albertijn, 1; H. J. Selby, 2. Time, 17 3-5 secs. Won by 12 yds.

120 *Yards Hurdles Handicap.*—H. J. Selby (5 yds.) 1; W. Leslie (5 yds.), 2. Time, 19 1-5 secs. Won by 5 yards.

Throwing the Hammer.—B. Cilliers, 71ft. 6ins., 1; G. G. T. Tregarthen, 59ft. 4½ins., 2.

Putting the Shot.—P. K. Albertijn, 32ft. 7ins., 1; F. G. Hutchinson, 31ft. 9ins., 2.

Long Jump.—C. L. Steyn, 20ft. 10ins., 1; E. E. Neser, 19ft. 0½ins., 2. Hospital record.

High Jump.—F. R. Taylor, 5ft. 2½ins., 1; S. S. Suzman, 5ft. 1½ins., 2.

Relay Race.—Medicals easily beat the Dentals.

Tug-of-War.—Dentals beat Men in Wards by 2 pulls to 1.

Staff Race.—Herberts, 1; Davis, 2.

Band Race.—Bandsman Carwood, 1; Cpl. Farley, 2.

Honor Oak Park Coronation Scurry Stakes.—E. L. Sprong.

Clement-Lucas Challenge Cup.—C. L. Steyn, 20 points, 1; P. K. Albertijn, 19 points, 2.

Inter-Hospital Athletic Sports.

On Tuesday next, the 28th inst., the competition for the Inter-Hospital Athletic Shield is being held at Queen's Club, Baron's Court, commencing at 2.30 p.m. Guy's are the present holders, having made a sweeping victory last year of 82 points to Bart.'s score of 22 points for second place, but this year it is more likely to be the odd two points that separate the first two Hospitals. Steyn, who last year won four events, is only entered for three this year and will have to go all out to win these from Ainsworth-Davis of Bart.'s. Ainsworth-Davis was one of the quartette, who won the 1,600 metres relay race for England at the last Olympic games and only last Sunday was doing great things against the Frenchmen in Paris. Albertijn, our first string in the hurdles, will also be up against a tough proposition, in the shape of Banks of U.C.H., his conqueror in the University of London hurdles. We have no miler in the Hospital, who can touch Lightwood of K.C.H., who is also quite likely to beat Housden in the three miles. Altogether we are in for a very stiff fight, at least four of the seven hospitals, who have entered, being in the running for the Shield. The entire meeting will be considerably above the average and records are sure to be broken, but we are willing to lay long odds that the Shield will still be seen in the College dining-room, if only a sufficiently large muster of Guy's supporters turn out to cheer on the team. Admission to the ground is only a shilling and Queen's Club is very easily reached by "District" trains from the Monument. *This is the most important summer Inter-Hospital fixture.* DON'T MISS IT!!!

Guy's Hospital Rifle Association.

The first shoot for the Armitage Cup took place on June 8th; the following were the scores :—

W. H. Foy	85
G. Beamish	83
M. Weinbren	82
J. Barnes	80
J. Bingay	78
J. Meckelburg	67

The shooting was not what it might have been, as weather conditions were not conducive to good shooting. It is hoped that in view of the forthcoming competitions all interested will turn out, as it is imperative to do some practice shooting beforehand.

The second of the four shoots for the Armitage Cup was held on June 15th, when there was a decided improvement, the following being the scores:—

W. H. Foy	92
W. Elkington	90
J. Bingay	88
G. Beamish	85
G. Barnes	82
M. Weinbren	78

Great satisfaction was expressed at Mr. Thompson's having been able to go down and shoot; he made top score at 600 yards.

Football.

ASSOCIATION.

At a General Meeting held on Monday, June 20th, with Dr. Fawcett in the chair, the following officers were elected for Season 1921—22.

Chairman—Dr. Fawcett.

Captain—D. J. O'Meara.

Vice-Captain—L. S. Williams.

Hon. Sec.—W. S. Brittan.

Asst. Hon. Sec.—J. C. Hewetson.

Committee—Messrs. L. S. Williams, C. A. Wakeford, F. R. Payne, R. Van Geuns, E. Hardy.

Representatives to "Blues Committee."—D. J. O'Meara, D. H. Couch.

The meeting was very poorly attended; there ought to be more than a dozen "soccer" men sufficiently interested in the club to turn up for the election of the officers for the coming season.

Lawn Tennis.

The Guy's VI. met St. Thomas's Hospital in the Second Round of the Inter-Hospital Challenge Cup on Thursday, 9th June, on their ground. Guy's were fully represented, except for M. Jackson, his place being taken by E. Neser, who has been showing consistently good form.

The following represented Guy's:—L. Nurick (Capt.), B. Keyter, A. Daneel, P. Albertijn, J. Jacobsz, E. Neser.

We won a decisive victory by 11 matches to nil. If this form is maintained there is every prospect of yet another cup being added to the wonderful collection in the Smoking Room.

On Sunday the 12th, Guy's II. VI. met St. Thomas's on their ground and won by 11 matches to 1.

The following turned out for Guy's:—B. Laver (Capt.), — Becker, L. Phillips, — Morgan, J. Schollum, T. Shaw.

Becker was unfortunate in being the only one to lose a match. The second string have been playing consistent good tennis, and we have hopes of bringing off a double event in the Cup Ties.

On Saturday, 19th June, Guy's had their first reverse of the season, when they lost to Kew by the narrow margin of 5 matches to 4. It was a very close game and the result was not decided until the last set was played.

Nurick and Jacobsz played very well and won 2 matches, Jackson (Capt.) and Albertijn, Daneel and Neser, won 1 match each.

Nurses' Lawn Tennis.

On Wednesday, June 8th, Guy's played their first match in the Inter-Hospital Nurses' Lawn Tennis Tournament. We had been drawn against King's College Hospital, and exceptional interest was evoked in this tie, as it was King's College that defeated us last year in the semi-final for this cup.

The match was played at Denmark Hill, on the King's College Hospital hard courts. A large gathering witnessed the play which proved most exciting.

In the first match the Guy's team (Nurses Vian and White) started badly, losing their first five games. They then found their game, and, winning three consecutive games brought the score to 3—5, only to lose the next game, and so the set at 3—6. However, the next set they won 6—3, and so turned the tables on their opponents. The third set was very keenly contested. Guy's at first led 3—0, but King's reduced this lead to 3—2, when our team went ahead again to 5—2. But we had not yet won, for the next two games went to King's, and the score stood at 5—4. It was Nurse Vian's service, and playing brilliantly, she won her service game, and so the set and match.

After tea the second match was played, Guy's being represented by Nurse Stubbs and Nurse Johnson. Our team won a well-contested first set by 6—2, a score which hardly reflects the fight which the King's team put up. In the second set, however, Guy's did not maintain the same form, and were rather easily beaten by their opponents by 1—6. Again the score stood at set all. This reacted upon the play of both teams, for each, anxious to win the last set, played a safety game which involved an inordinate number of long-protracted rallies in which the players stood well back on the base line and lobbed the ball tirelessly backwards and forwards until at last it went into the net or out of the court. Guy's, however, proved that they were the better team by winning this last set by 6—2.

Thus we won both matches and so revenged our defeat of last year. In the next round, Guy's play Joyce Green Hospital, and we trust that our team will be equally successful in this and in the succeeding rounds.

Mrs. Mollison is to be thanked for the trouble she is taking with the team, especially for the loan of her car to take to Honor Oak Park for practice. This is a very real help in these days of transport difficulties, and our success so far is in no little measure due to Mrs. Mollison's help and encouragement.

ED.—A. T. R.

GUY'S HOSPITAL GAZETTE.

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Passim.

IN the days before the war, we used to have a yearly garden party at the Hospital, when all our friends congregated to listen to speeches, and to watch the prizes for the year being distributed. The garden party also provided an opportunity for those who had heard much, but seen little, of the Hospital, to judge of its wonders for themselves. Since the war we have had no such chance of showing the Hospital to our friends. Next Friday, when the Prince of Wales comes to unveil the War Memorial, the first post-war garden party will be held. It will not, however, include the prize distribution this year, as, following the precedent set up last year, we are making this function quite a private one. The distribution will take place quietly, and without any elaborate ceremony, on Thursday next. The men who have won prizes will receive them in the presence of their fellow students only. There will be no strangers present. There will be no long speeches, but everything will be done simply and without formality. It was found last year that such a gathering was far more satisfactory, and far more impressive, than the pompous ceremonies of pre-war days had been. The only objections raised last year were that by doing away with the garden party we were destroying one of the greatest of the social functions of the Hospital. But, of course, there is no reason why the prize distribution should be the *raison d'être* of the garden party. We sincerely hope that in future years there will still be set aside one day, at least, during each year when the Hospital shall be open to all those who wish to visit it.

The arrangements for next Friday are now nearly complete. Invitation cards have been sent to the relatives of the fallen men, but, as we pointed out last week, we cannot hope to know the addresses of all those who should have received these invitations, so we would remind any who have not received them that cards will be sent to them at once, if they will apply to the Honorary Secretary of the Memorial Committee.

It seems that many men have been uncertain as to what is exactly meant by the vague directions, "Academic or Morning Dress," which are printed on the invitation card. We have ascertained that the Committee do not mean by this that they wish all men to be present either in caps and gowns or in morning coats and silk hats. They do not expect to see many of the present students turning out in anything but the customary lounge suit. On the other hand, they do ask that all the members of the staff and as many of the qualified men as may be

conveniently possible, will be present in the academic dress, so that this garden party may emulate the distinction of those of pre-war days.

WE have received a letter from Mr. Ormond reminding us of the forthcoming Biennial Dinner. It is hoped that this Dinner will be even more successful than was the last "Biennial." As this letter shows, he is endeavouring to ensure that all who are present shall be seated among their friends and contemporaries. We would therefore ask all those of our readers who can possibly manage to be in London on October 26th to study the list of Chairmen which will be found in Mr. Ormond's letter (on page 269), and to write to Mr. Ormond, telling him at whose table they would like to sit.

WE have lost by the death, on July 5th, of Sir George Savage, one of the best known and best loved of our consulting staff. Sir George always took great interest in all that was happening at the hospital. He was President of the Physical Society, and only last year lectured to this society on his favourite hobby of mountaineering.

DURING the last fortnight a remarkable number of international sporting contests have taken place. The whole world has been excited over cricket, rowing, boxing, tennis, golf and athletics, to say nothing of such less common, though no less exciting, sports as flying and motor-cycling. Though we cannot claim to have added anything to this general excitement over sport, yet in this fortnight a record number of inter-hospital contests have also taken place, and, after all, these matches mean almost more to us than do the games at Wimbledon, at Leeds or at Henley.

We were not able to retain possession of the Inter-Hospital Shield for Athletics, for after a keen contest we were beaten at Queen's Club by King's College Hospital by 4 points. The success of King's was due almost entirely to the magnificent running of Lightwood, who won three races for them, and who was the chief cause of their winning the relay race. For Guy's, Steyn did remarkably well. Both in the 100 yards and the 200 yards he easily beat Ainsworth Davis, the Bart's. sprinter, who was one of England's representatives in last year's Olympic Games.

AT the Inter-Hospital Meeting at Bisley we were far more successful, for not only did we win the Armitage Cup, but we also won seven out of the twelve minor cups which were put up for competition.

Fortune also favoured us at the Bath Club, where we were the winners both in the swimming and in the water polo. Here also the nurses showed that they too can win inter-hospital events, for they carried off the swimming cup which was presented this year by Sir Alfred Fripp for competition between the nurses of the various hospitals. We are all very grateful to the Matron for allowing the nurses to compete and for the interest she took in their swimming.

In cricket we easily defeated St. Mary's in the semi-final round—4 wickets and 162 runs. In the junior competition we also passed into the final round by beating London Hospital, who were dismissed for 27 runs, largely owing to Newton's bowling.

WE reached the last round of the Senior Tennis Tournament by defeating the London Hospital by 10 matches to 2, whilst in the Junior Tennis we had an unexpectedly easy victory over Bart's. in the semi-final. The nurses too played and won their match against Joyce Green Hospital in the second round of tournament with the greatest of ease.

IT is with the greatest pleasure that we offer our congratulations to Mr. Maizels on his gaining the Treasurer's Gold Medal in Clinical Medicine, and to Mr. Couacoud, who has won the companion medal for Clinical Surgery.

IN this number of the GAZETTE we publish the first of the series of letters on General Practice which have been specially written for us by a general practitioner who insists on hiding his identity under the pseudonym of "El Hakim." As our readers will find, these letters are full of sound advice on many minor points of practice which often baffle the beginner.

ONE of the nursing staff was recently heard to say that she did not think much of men whose highest ambition was to qualify L.O.A.

THE College Matron tells us that for some time past the long roller towels have been disappearing one by one from the basement in the College. Attempts were made to prevent their wandering by putting padlocks on the hangers. But this did no good for the locks were broken and the towels taken. It seems absurd that anyone should take all this trouble in order to steal a towel. We do not know who this collector of towels is (the externs assure us *they* are not using them as pulleys or binders), but we hope that if he reads this paragraph he will see the error of his ways and will return his collection to the Matron.

IN our last Passim we inadvertently used a badly chosen figure of speech when we spoke of the chances of improving the GAZETTE. We have been repeatedly told that there is nothing vicious and nothing circular in the picture which we drew. Most of our correspondents have satisfied themselves with suggesting a beneficent spiral as a more appropriate term, but one more erudite than the rest assures us that what we meant was "the Eccentric or Ionic Volute." Perhaps we did, but we were not aware of it at the time.

WE were very glad to hear that Mr. E. C. Warner had been awarded the University of London Studentship of Physiology for 1921–22. This is the only physiology studentship awarded by the University this year, and there was therefore a keen competition. We believe that this is the first time that this honour has come to Guy's.

IT has been suggested that it would be better if we published clinical lectures in the central pages of the GAZETTE, so that they might be abstracted and bound separately for future reference. The average size of these lectures is six pages, and this number cannot be abstracted without causing some damage to the remaining part of the GAZETTE; nevertheless, we think that this idea is worth a trial, and in future numbers we will try to adopt it.

THE Clubs' Union Year Book for 1921–22 is now being prepared, and Mr. Winston will be glad to receive particulars as soon as possible at the Medical School Office of the achievements of the various Clubs during the season 1920–21.

Papers by Guy's Men.

W. M. Mollison, F.R.C.S. Dyspnœa and Tracheotomy.—*Clinical Journal*, 1921, I., p. 385.

——. Two Cases of Lateral Sinus Thrombosis without Otorrhœa.—Proc. Roy. Soc. Med., xiv., Sec. of Otology, p. 42.

Sir William Hale-White, K.B.E., M.D., F.R.C.P. Pleurisy.—*Practitioner*, 1921, cvii., p. 4.

——. Discussion on the Medical and Surgical Treatment of Graves Disease.—Proc. Roy. Soc. Med. Clinical Section, xiv., p. 14.

Dr. J. M. H. Campbell. The same, p. 38.

C. Worster-Drought, M.A., M.D., M.R.C.P. Lesions of the Posterior Tibial Nerve.—*Brain*, 1921, vol. xliv., Part 1.

Case Records in General Practice.

A Lecture given by Dr. H. M. STEWART in the Clinical Theatre on Tuesday, June 21st, 1921.

GENTLEMEN,—I do not know whether you spend—or waste—much of your time in reading law reports, but if you do you may remember that a short time ago there was a case in which a lady—an actress who was unmarried and doubtless of irreproachable reputation—brought an action against an illustrated paper for publishing a picture of herself with a small child which the paper stated to be hers. Well, no doubt it was tiresome and annoying, but I thought when I saw that account that the advertisement which the lady got quite compensated for any inconvenience she had been put to. I feel that I am in that position to-day, for though it was a little unfortunate that the day originally fixed for this lecture coincided with one of the cup matches, I have as a result got an advertisement which is, I fear, beyond my merits, though not, I hope, beyond the merits of the subject on which I am going to talk to you.

In the course of a conversation a short time ago with Dr. Hurst, the subject of case records came up, and Dr. Hurst asked me to come and talk to you about keeping records in general practice; it was after dinner and I rather rashly promised to do so.

It is possible that you have never had occasion to give any thought to the subject because you know that here records are kept regularly—when you are clerking you keep them yourselves, but when you get to the higher appointments they are kept for you, and uuless you form the habit of keeping them you may find it irksome to start again.

Now I think a subject like this is better suited to an informal talk, so I do not propose to apologise for not giving you anything that could be called a lecture, and I hope that if in the course of what I say anything occurs to any of you, you will not hesitate to ask questions, so that we may talk it over together; nor shall I apologise to you if I become egotistical; after all, it does not pretend to be anything more than my own experience—the experience that everyone gets after a good many years of practice.

Now I expect that most of you know the story that is told of Abernethy, how that one day on coming into the lecture theatre at Bart's he stopped short on seeing the large number of students in front of him and exclaimed, "Good God! what's going to become of you all?" Well as far as the great majority were concerned, and to give only a superficial meaning to his question, the answer was obvious, they would become general practitioners. The same applies to you though not, perhaps, to the same extent, as there are so many branches of practice open to men now which were not open then—but still in the main it is true, most of you will become general practitioners. What will become of you afterwards is another question, a question which is causing a good deal of searching of hearts just now when general practice, family practice, is rather in the melting pot. In spite of this fact that the majority of medical students will become general practitioners, there is very little thought given to the subject either by the men themselves or by their teachers in hospitals or, rather, I should say, has been given up till quite recently. For if it were not being done now I should not be here to-day, and I congratulate you that you are having opportunities of learning something of what your life will be after you leave the hospital. It may be a painful and expensive experience to learn it later. Apart from purely medical work, there are many aspects of practice which demand attention. There is the business side, for instance; most of us do not practice medicine for the good of our health, but with the hope of earning a living thereby, and if you commence by buying a practice or a partnership you must see that you are likely to get good value for your money. Just in passing let me say that I think the best thing to do is to get an experienced friend to advise you rather than simply to employ a solicitor to draw up an agreement, because a man who has been in practice is bound to know the difficulties that are likely to arise and the best way to avoid them. Then there is the subject of your relationship to other doctors.

It is a very important part of your lives and one that must be thought about; you should come to a decision as to the line you are going to take as soon as you start in practice. I am sorry that the custom of newcomers calling on their medical neighbours does not seem to be observed as regularly as it used to be. Most of the troubles between doctors arise through their not knowing each other, and I should advise you to make a point of knowing your

neighbours, of joining medical societies and of taking an active part in the local organisation of the profession. Nor must the social side of your life be neglected; it is also an important part of your life. The main difference between hospital practice and private practice is, I suppose, that in private practice we enter so much more into the lives of our patients. Here you are learning about diseases and naturally tend to treat diseases; in practice you treat patients—a very different thing. For example, a man came to see me the other day with a tiresome condition of his feet; he had a stiff knee, and as a result of faulty walking had got an ulcer on the sole of his foot. From a purely medical point of view one knew perfectly well what to say to him. "You must go to bed; you'll never get that ulcer well while you are walking about on it." "But" he replies "I'm a married man with a wife and child to keep, and twenty-five per cent. of the men at my work were discharged this morning. If I'm away for a week I shall lose my job and then I shall go short of food." Is that likely to help the ulcer to heal up? Of course you know it is not, and you know you have got to help the man to carry on as best he can. That is one example of how you must enter into the lives of your patients.

I'm afraid, when I was here at the hospital, we used to rather look on the G.P. as a sort of rotter whose chief object in life was to bluff an unsuspecting H.P. or Clinical into taking in a chronic or otherwise undesirable case. Believe me, there is much more in it than that; it is not easy to be a general practitioner; you must have at least a good working knowledge of medicine and surgery, for even if you do no surgery yourselves your patients will be guided by you as to the advisability of operations; then of course midwifery, gynæcology, and children's diseases are the backbone of general practice, while you must be prepared to diagnose if not treat conditions connected with the more special subjects, such as eyes, ears, skins, throats, mental diseases; you must also be prepared to discuss the latest medical stunt being run by the press, and you must be ready, if not able, to advise your old lady patients on their financial and domestic affairs. I think one of the most amusing things I have to do is to draw regularly my own cheque for attendance on an old lady who finds paying bills very irksome, and always asks me to write her cheques. Nor must one forget education which has many important medical aspects, and if all this is not enough for you, you may have the experience of a medical friend of mine who was recently roundly abused because he said he was really unable to provide accommodation for a stray female who had been turned out of her lodgings.

Another idea we used to have was that there were no interesting cases in general practice; I wonder where we thought the good cases came from. I can only tell you that the man gets "good" cases who recognises them when he sees them. There is an immense amount to be learned before one can make good in general practice, but I am not proposing to give you a sort of Samuel Smiles talk on how to be successful. For one reason, that would involve us in a discussion as to what is success. It means such different things to different people; to one man it means making as much money as possible, to another making some definite advance in medical science, to another helping as many lame dogs over the stile as possible. I think, however, one can say this, that you cannot achieve any sort of success unless you either do good work, or else persuade the public that you do. Now the character of your work depends on many qualities. some inborn and some acquired, and it is of one of these latter that I want to talk to you, and that is methodical habits, as illustrated by keeping records of your cases.

The first question that arises—I suppose it arises—is, Is it worth while? It is rather unfortunate that this question should arise for we ought to put in the best work possible without thinking whether it is worth while or not, but the demand for cheap labour has taken away from the workman his pride in his work and everyone seems to be affected in the same way to some extent. This question, as to whether it is worth while to keep records, has arisen rather acutely lately in connection with National Insurance work and probably you have seen some of the correspondence in the medical or lay press. The point that has been most hotly debated is whether the method adopted by the Government is the best. On that people may have different opinions, but that the keeping of records is of value I have no doubt whatever.

One has to consider the subject, as so many in practice, from three points of view. First of all there is the patient's point of view, for we must never forget that our first duty is to our patients and all other objects must be subordinated to that. Let me illustrate this by an extreme case: however desirable it is to take

every opportunity to learn all we can about shock, no one would suggest leaving a patient bleeding while observations were made on the rate of fall of blood pressure! Now it is to be hoped that the day will come when the public will recognise that a doctor's job is not only, or so much, to get them well when they are ill as to prevent them from getting ill. This is recognised, of course, in state medicine-hygiene, notification of infectious disease, isolation of the infected, vaccination, etc.; all have as their object the prevention of disease but the necessity for this is not sufficiently realised in every day life; is it too much to say that every man or woman over forty should be examined by a doctor once in six months? and when I say examined I do not mean a casual glance at the tongue but a thorough overhauling with a careful review of the patient's mode of life. Sir James Mackenzie has rightly laid stress on the importance of recognising early symptoms, but it is a case of first catch your hare, then cook him, and we must train our patients to come to us before there are symptoms or at any rate symptoms which they can recognise.

How often does a case of this sort occur; a man of, say, 50 comes to you, not because he feels ill, but because he wishes to increase his life insurance, he is in the prime of life, at the top of his earning capacity, perhaps the head of a large business, working his brain hard during the day and his stomach at night, probably smokes a good deal and has several whiskies at odd times; such a man will declare himself to be in perfect health and is bursting with energy and spirits, but you find that his blood pressure is above the average for his age, his aortic second sound is rather sharp, and his radial artery can be palpated rather more easily than it should be. Now every detail of that man's life wants careful consideration—food, drink, tobacco, hours of sleep, and work, recreation and exercise must all be regulated and revised as time goes on. How can you do this properly unless you have recorded the condition in which you find him at each consultation? or again, take such an ordinary case as early phthisis. I remember that Sir William Hale White used to tell us that if he were limited to the use of one instrument in the management of a case of phthisis he would choose a pair of scales, but your scales will not be of much use to you or the patient if you do not keep a record of the result of your weighing, for you cannot possibly remember the weights of all your patients and it may not be desirable to tell the patient what his or her weight may be. Such types of cases might be multiplied indefinitely, but I need not labour the point, and think you will agree with me that record keeping is desirable from the patient's point of view.

Now what about the scientific point of view? We hear a great deal now-a-days about Anti-waste campaigns and the need for economy, but has it ever occurred to you what an appalling waste there is in general practice—waste of knowledge gained by long years of observation and experience? Doctors have the reputation of talking "shop" whenever there is an opportunity, and it is true that you will seldom meet a brother practitioner without hearing of some interesting or difficult case, or of some unexplained feature in an apparently straightforward case; but these observations lose much of their value because the exact details were not noted at the time, nor are the cases collated and the errors of small numbers allowed for. It is true that few of us can carry out researches which require laboratories or pathological material, but what a simple observation it was which led to the discovery of vaccination! You may say "Yes, but we are not all Jenners"; that is true, but if you train your powers of observation you may do valuable work in proving or disproving the theories of others whose minds may be more fertile in ideas. How much easier it would have been for Jenner if he could have enquired of his brother practitioners with a certainty of getting accurately observed data? We are inclined to remember the ingenious instruments which Sir James Mackenzie has devised, but, if I am not mistaken, he himself attaches more value to the long and careful observations which he made on the course of certain diseases of the heart.

There are many questions which general practitioners are specially qualified to investigate. For instance, the possible connection between herpes and varicella has attracted a good deal of attention of late; they are both diseases which come before the general practitioner, and most men must have many opportunities of observing their relationship to one another, but how many men have made use of this opportunity? A short time ago I was talking to a medical neighbour about this subject and found that he had not noticed any of the communications dealing with it in the medical press; I asked him to pay attention to it and the next time I saw him—about a month later—he told me that he had had a case of herpes followed by a case of varicella within a

fortnight in the same house. I cannot help thinking that if he had been in the habit of keeping records the connection or coincidence would have struck him before then. Then the early symptoms of disease, to which, as I have already mentioned, Sir James Mackenzie has urged us to pay more attention, must come before the general practitioner first, and there is a wide field of research waiting. Then, again, take the results of treatment in the large class of cases which do not go into hospital; that is a subject on which the general practitioner should be able to throw a great deal of light. These examples are sufficient to show that from our second point of view the keeping of records is worth while.

Thirdly, how does the doctor himself benefit? You will remember that Bacon says "Reading maketh a full man, conference a ready man, and writing an exact man." It is exactness and accuracy that we want, and I think most men would hesitate to put down in writing a vague or careless diagnosis which might satisfy them if they did not have to face it in black and white. It is so dangerously easy, too, to think you have made a diagnosis because certain possibilities have passed through your mind when examining a case, though, as a matter of fact, you have made no diagnosis at all; from this state of mind you learn nothing, while, whether you are right or wrong, you always learn something by committing yourself to a definite diagnosis.

I wonder if you still have sweepstakes in Clinical on the difficult cases; we used to do so, and all had to plump for something, and a small contribution to the pool gave a little additional excitement. Then the mere act of writing often draws your attention to some point which you may have noticed but to which you have not given its proper value. I remember some years ago sending here a patient who had a lump coming forward from the right loin, and there was also pain referred to the upper and inner part of the thigh. I took the lump to be the kidney, and when the abdomen was opened this proved to be the case, but it was a normal kidney pushed forward by an inflammatory mass which involved the ilio-inguinal nerve, and I think an accurate and complete diagnosis might have been made if one had paid more attention to the referred pain. Apart from diagnosis, one cannot estimate the progress of one's cases without records, and one therefore fails to acquire that skill in prognosis which is said to be the special perquisite of the general practitioner. One of the most difficult things in practice is to give an accurate prognosis—not as to whether a patient is going to live or die, but as to how long it will be before he can resume his ordinary life; as a matter of fact a patient very rarely asks his doctor whether he is going to recover but always wants to know when he will be able to work or play again. Then in these days when certificates are demanded for every conceivable reason you are often required to state the condition of the patient's health at a particular time, and for this purpose records are absolutely essential. You will come down badly some time if you make a habit of writing certificates from memory for "you can fool some of the people all the time or all the people some of the time, but you cannot fool all the people all the time"; more important still is it when you have to give evidence in a court of law for notes or memoranda taken at the time may be used to refresh the memory. With regard to notes in legal cases there are one or two points which it is as well to bear in mind. First, if you produce notes they can be demanded by the cross-examining counsel, so it is as well to be careful what one puts down. Secondly, notes can only be used if they were made at the time of, or very shortly after, the occurrence to which they refer; also the notes must be made by the witness himself, or if by another they must be reviewed by the witness at the time and can only be used to refresh the memory and not to bring forward fresh facts which the witness had forgotten, so the witness must be prepared to swear to the point on which he is testifying from his own recollection. In these cases there is a definite, if small, material reward for your work, but I would not have you think that record keeping in general is without its immediate material reward. For instance, Life Insurance is honourable and remunerative work and you can earn fees easily if you have records of your cases, for you are frequently applied to by Insurance Companies for a statement as to a proposer's health, and a record enables you to give this and earn your fee with a minimum of trouble. The ultimate material reward is of course undoubted, and I well remember Professor Adams telling me many years ago that Sir William Osler attributed all his success to his habit of careful note-taking.

Now, you will ask me whether there are any drawbacks to record keeping. I do not know that there are any real drawbacks, but, of course, it does mean a certain amount of work,

and the general practitioner does not, as a rule, have too much time to spare, but the work is not excessive if done methodically, and I hope to show you how you can get the maximum result with the minimum of labour. You have also to put up with a good many disappointments because much of your work is wasted. Many of your patients will disappear, for one reason or another, while still under observation, and their records become of no particular value. Still, if you are not going to work when you go into practice I am afraid you have mistaken your vocation in life, for there is no getting away from it—general practice is hard work. Another possible drawback is that you tend to become very sceptical of much that you read and hear. It is, no doubt, more comfortable to take as gospel all that you are told, but if you do your own observing and your own thinking, you will find that this cannot always be done. To give you one example: It is, I think, commonly believed, not only by the public but by the medical profession, that second and even third attacks of the ordinary specific fevers are not at all uncommon.

Now the first thing that strikes one with regard to that is that the more definite and easily diagnosed the fever the less often do we hear of second attacks, while in cases where the diagnosis is more uncertain, then we hear frequently of these second attacks; does not this suggest that it is the diagnosis which is at fault? Thus varicella, as a rule, offers no difficulty in diagnosis, and we are very seldom told that a patient with varicella has had a previous attack, but measles, which means to the public morbilli or rubella, or the "fourth disease," or even any form of erythema, is said to occur often in the same patient. Well, I think, if you keep careful records you will come to the same conclusion as I have myself, namely, that the protection given by one attack of the exanthemata is very complete; at any rate I have not yet seen an undoubted second attack of measles. Of course I have frequently been told by parents that I have attended a child for the same illness before, but on looking up my notes I have invariably found that either this was definitely not the case or else that I have made a note to the effect that the original diagnosis was doubtful, as in mild or atypical cases it may easily be. This is of practical value in the case of schools, and when I am satisfied that a child has had one of the exanthemata before, I do not hesitate to allow him to mix with infected schoolfellows and have not yet seen reason to regret it.

It is now time that I told you something of the method of keeping records which I have found most satisfactory and at the risk of wearying you, will go into some detail as I have tried most methods and my object is to save you as much trouble and annoyance as possible. First of all you must realise the conditions under which you work. As general practitioners you will visit a large proportion of your patients and also you will continue to see them, or at least you hope to, for many years. This applies to an average general practice; of course you may be in a practice where a large amount of your work is done in what the Americans call their office, or you may be in a neighbourhood which is constantly changing its population, but if so it only affects some details of your methods. Now it is very important to make your notes at the time of your visit, and you cannot carry round with you a large volume of records, so that for this reason as well as because it is not necessary to keep permanently all that you note at the time, it is best to have small cards which can be conveniently carried in a pocket book and from which your permanent record is made. For this permanent record it is advisable to use a loose leaf ledger (there are many on the market and you can have them specially ruled if you wish); it is of course impossible to know how much space a patient will require, and if you use a bound book you must either leave a great many blank pages, with consequent accumulation of books, or else you will find that you have not allowed enough room and your notes of one patient are scattered about in various books.

The daily record cards are kept in a suitable box and are filed under the days of the month so that each day you have simply to take out the cards for that day's visits; incidentally this will often save you forgetting an appointment which may have been made some time earlier, as it provides an additional check on your visiting list. From time to time you must post your records into your permanent ledger, and in doing so you will find that much of the detail which it was necessary to note at first is no longer of importance, so the labour of making these records is not great. This permanent ledger will be indexed under the names of the patients, but for purposes of reference it is advisable to have a cross index of diseases, and this is most conveniently kept on cards similar to those used for the daily notes; for instance, suppose you wish to refer to some point connected with herpes, you have only to

take out your card labelled "HERPES" and there you find the names of all the patients you have treated for this complaint.

This leads me to say a few words about reading in practice; the output of medical literature is so vast that it is impossible to read carefully all that you may wish to, while it is necessary to know where to find articles that are important or have a bearing on some subject in which you are interested. To get over this difficulty I find it a good plan to make a note of such articles on the disease index cards, so that you have in front of you at the same time the names of all the patients who have had any particular complaint, and any articles of special interest bearing on this complaint. For instance if again I take this HERPES card I find down one side a list of patients' names, and, down the other, references to the *Medical Annual*, *British Medical Journal*, and the *Guy's Gazette*. Of course, one has come across many other articles, but as none of them appeared to throw any fresh light on the subject, they are not put down. So much for the outfit; now, what are you to put down? I do not think I need keep you long over this because you are trained here in keeping records, and that training will be added to and improved upon by experience. Sir James Mackenzie says it takes a lifetime to know what questions to ask a patient, and another lifetime, I think, to understand their answers, but even if we do not arrive at this perfect understanding we can still be adding to our own efficiency, and perhaps be adding something to the sum of human knowledge.

Do not waste your time in putting down obvious things; if you are satisfied that your patient has pneumonia you will state the fact and not bother to record the physical signs which led you to make the diagnosis, but always make a complete examination and make a note as to whether other organs than those mainly affected are healthy. It is sometimes of great importance to know whether, say, albumen in the urine or a cardiac bruit are of recent developement or not, and a note jotted down perhaps years before may profoundly modify your view of a case; always commit yourself to a diagnosis and to a prognosis, and in cases where you have a second opinion make a note of this opinion, and if it differs from your own put down the reasons which led the consultant to give it.

I have tried to show you the importance of keeping records and how this can be done without an undue tax on your time and energies, and have only to add that if you do this you will not only find your work doubly interesting, but will obtain a knowledge which is safe, because it is founded on the rock of your own observation, and you will enjoy the confidence of your patients who will realise that each one of them is the subject of your thoughtful care and study.

"The World, the Flesh, and . . . . the Doctor."

BY "EL HAKIM."

[AUTHOR'S NOTE.—In presenting the following series of articles on topics of interest, it is hoped that their lack of literary merit will be compensated for by the occasional illumination thrown on aspects of the medical profession hitherto ignored or neglected during the busy training of the young medico. Dogma has been avoided unless inevitable, and indulgence is pleaded from the Staff for this unofficial intrusion by one whose only plea is experience.]

I.

"Happy is the man, who, like Ulysses, hath made a goodly journey"—and as equipment is essential to the successful traveller along the "doctor's highway," it may be helpful to consider what things are to be kept in mind at the start, *i.e.*, when newly qualified. The knowledge possessed and vouched for by learned examiners, will be added to continuously; and *pari passu* with this accumulating inert mass *must* grow the powers of applying and making alive—education . . . . who does not know the exam-perfect, but otherwise futile student? Remember that a doctor worthy of that honourable name is a student all his life, and it is therefore of supreme importance to learn the art of studying for its own sake and that of one's intellectual growth—thereby enhancing practice.

It is very hard to resist the immediate use of the newly-acquired opportunity to exchange the needy student days for apparent prosperity and independence. In many cases, circumstances force one to qualify and "settle down" as soon as possible, but for the moment let it be imagined that such urgency is not calling.

One's bounden duty as a man of honour is to become as proficient as is honestly and humanly possible; and there is no better advice for the newly qualified to follow, than to do all available appointments during the first two or three years, adding meanwhile, if possible, letters expressive of academic successes to his surname.

The latter by no means implies an exclusively "stuffy" bookworm existence; anyone doubtful of this conclusion should carefully compare the list of athletic successes with that of academic honours. It is perfectly easy for a man to work hard and play hard, and each doctor should be a living example of *mens sana in corpore sano*.

The word "specializing" should find no home in a budding medico's vocabulary; and it cannot be too strongly emphasized that before daring to specialize it is absolutely necessary to lay a sound foundation of efficiency and proficiency in each branch of medicine.

By no means should legitimate ambition be stifled, but let it be realized that there is disaster in attempting short cuts to London W.1!

On the whole, immediate registration in accordance with the regulations of the General Medical Council is advisable, and here may be recommended the wisdom of keeping in touch with medico-ethical matters, usually dealt with in the columns of the leading periodicals—the *British Medical Journal*, *Lancet*, etc.

The young man may ask, "What about a short voyage, or a locum, or a holiday, before re-starting?" By all means take a holiday, but avoid too long or too profound a sojourn in the outside world, as you may thereby become unsettled and restless. It is only in after years that you will realize how short, but how essential were these few years extra-to-the-curriculum, and how you might have had your taste for further study spoilt by failing to carry on whilst in the *Alma Mater* atmosphere. Of course, you can do far worse than accept a post at some outside institution, the remuneration often being in inverse ratio to the professional value of the appointment.

The point to remember is that post-graduate knowledge is far more smoothly acquired in direct sequence, than after years of practice, during which you will have incurred many obligations and gone probably into a fixed groove.

A few "Dont's" may not be out of place at this juncture:

Don't get rid of your microscope and your slides and odd class notes. Their value as stimulants to memory and as aids to perspective will increase as time goes on.

Don't buy indiscriminate masses of books. Use libraries, and exercise a connoisseur's judgment in deciding on the merits of publisher's announcements.

Don't imagine that being qualified has licensed you to become too "superior" to gaining experience, and do not fail to grasp every conceivable opportunity to examine patients—acute or chronic.

When you admire Sir X.'s snapshot diagnosis, *don't* forget that his power has been gained by decades of incessant attention to minutiæ and constant examinations of patients.

Don't forget that you deal with sick *human beings* whose *tout ensemble* includes very real psychological entities; and as your conception and realization of physical ailments depends on an intimate knowledge of "normal" anatomy and physiology, so your appreciation of psychological abnormalities pre-supposes a clear idea of the healthy workings of the human mind. Even in the most trivial cases you cannot afford to overlook the non-physical elements, and it is therefore incumbent upon you to amplify and apply your text-book studies in psychology by close observation in wards, "out-patients," and in everyday life.

Don't miss the high importance of keeping yourself fit; and incidently, get insured—"Death, or at 60, and accident *cum* sickness," the younger the cheaper. A busy medico cannot afford to be "laid up."

Don't leave Guy's without having learnt all the tiny details of side-issues, such as sterilization and preparation of sutures and ligatures, all the dispensing tricks and practical knowledge of dietaries. Sit at the Sisters' feet—you'll be thankful in after years in tending some isolated case alone. One old Guy's man learnt that ether was *verboten* near naked lights from an old fashioned Gamp, and afterwards ruefully acknowledged his inattention to such small stuff as a student!

In concluding this section a few positive "Dicta" may set off the Dont's!

Keep clean: patients—be they Boro'ite or Baronial—are very susceptible to dirty hands and "shoddy" clothes in a doctor.

Visit your patients with as little "reek" as possible of tobacco or other odours as company.

Keep your dignity without being dictatorial and avoid crude bedside methods.

Be your own natural self and not a servile imitation of any senior in clothes or manner.

Keep an open and receptive mind towards the various schools of thoughts on any subejct, avoiding speech interlarded with stock terms that impress no one.

Be frank with teachers, and ask their help in all things. They are really very human and take a tremendous interest in your welfare.

Cultivate hobbies in addition to the more robust exercises. The Public expect you to be cultured outside the field of pure medicine and its interests.

The next instalment will consist of a review of the actual plunge into the world, and a discussion of the various openings, etc.

Appointments.

C. Worster-Drought, M.A., M.D., M.R.C.P., (1) Assistant Physician, West End Hospital for Diseases of the Nervous System; (2) Lecturer in Neurology, Bethlem Royal Hospital.

H. Millett, L.R.C.P., M.R.C.S., L.D.S., Honorary Dental Surgeon to the Evelina Hospital for Children, Southwark.

Change of Address.

H. Millett, L.R.C.P., M.R.C.S., L.D.S., 22, Oakley Square, Hampstead Road, N.W. 1. Telephone: Museum 2704.

T. Morland Smith, The Hive, Exeter Road, Bournemouth. Tele. Bournemouth 666.

A Case of Rat-Bite Fever.

CASES of the above are so uncommon in general practice that I think the following history of such a case may be of interest to some of the readers of the GAZETTE.

E. A., a patient of mine, aged 56 years, by profession a farmer, had never had a previous illness. He was out in the early part of January last rabbiting and after putting his hand down a rabbit hole, had his thumb bitten by a rat. There was little hæmorrhage and the wound quickly healed. Two weeks later it became swollen and bluish in colour, but did not discharge. About the same time a swelling about the size of half-a-crown appeared above the wrist joint on the radial side of the thumb, which quickly broke down and discharged pus. Both places quickly healed with hot fomentations and caused no further trouble.

I was asked to see the patient on account of the above places on January 14th. He said he felt ill, and had a cough with slight mucoid expectoration. Temperature was 104°, pulse 120°. No lymphangitis was present, and no enlargement of glands at the elbow or in the axilla. He quickly improved. Expectoration passed off, and a few days later, after a normal temperature for several mornings, was able to get about.

On January 28th I was called to see him again as he had not felt well for three days, and was delirious at night times. Temperature was normal. The patient improved and went out in a few days, and attended to his business.

February 16th.—The patient came to see me again, and as he appeared ill, I advised his returning home and staying in bed for a few days. It appeared to me that he was having a succession of severe colds, as no physical signs were present in heart, lungs or abdomen. The urine was normal and free of albumen and sugar.

Sputum test for T.B. was negative. There was no anæmia, no discoloration of mucus membranes, no alteration of stools in colour or frequency, no splenic enlargement, C.N.S. normal. There was no rash on the skin.

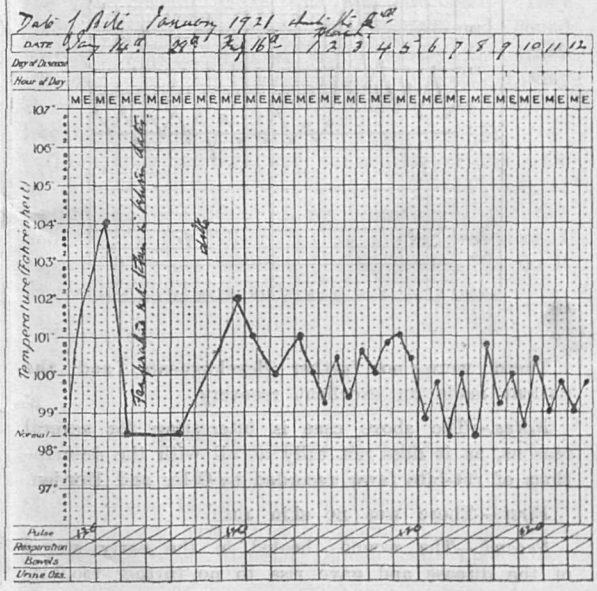
Fortunately I arranged for the evening temperature to be taken and it was clear the case was one of continuous fever with nothing—as far as I could gather, and also several other medical men who saw the case with me—to account for it.

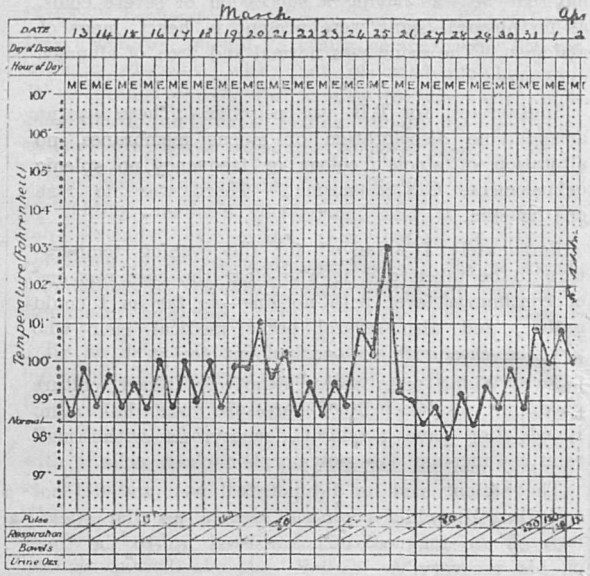
Two Widal tests were negative. Blood culture gave no results. Blood pressure was 140 m.m. Blood film gave a slight leucocytosis with small relative increase of polymorphonuclear cells.

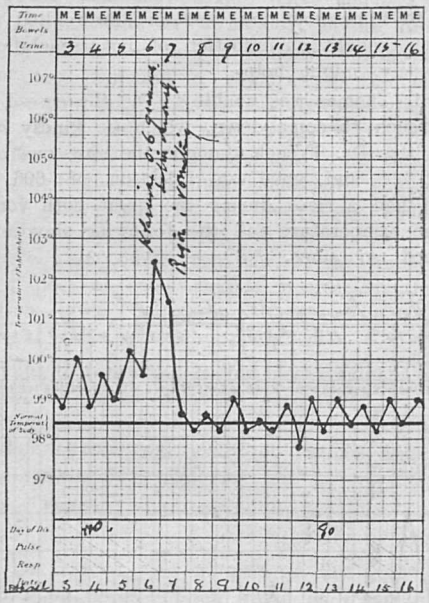
The patient said he did not feel well and did not feel ill. His chief complaint was a peculiar stickiness of the tongue which persisted up to the time of his recovery.

As there had been another case of rat bite fever in the district which Sir Thomas Horden had seen, I wrote to him about my case and he replied saying that he thought an injection of novarsenobillon intravenously, might help.

As Sir Thomas was unable to see the case I asked Dr. French to come down, which he kindly did on April 6th. Dr. French thought the case one of rat-bite fever and gave an injection of 606. The patient had a rigor during the night with vomiting, but the temperature fell the following day and has remained so since.







There were no further developments, and the patient made an excellent recovery.

Notes.—The above case is interesting for several reasons, as it does not tally at all with the descriptions of rat-bite fever recorded by Osler and Horden.

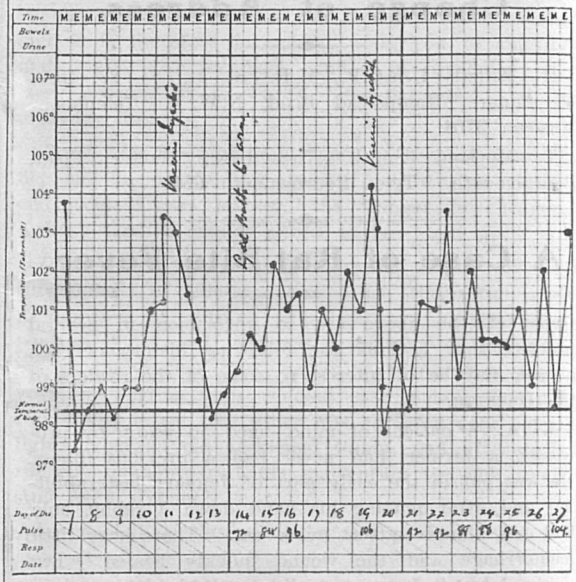
First.—There was no skin rash.

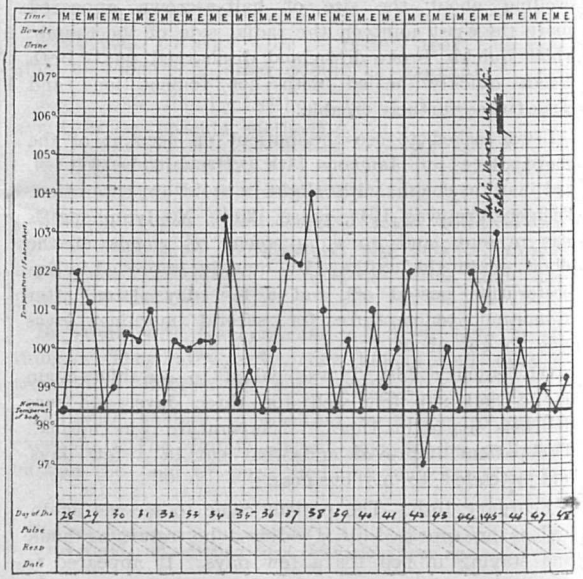
Second.—The wounds healed in the early stages of the disease and gave rise to no further trouble.

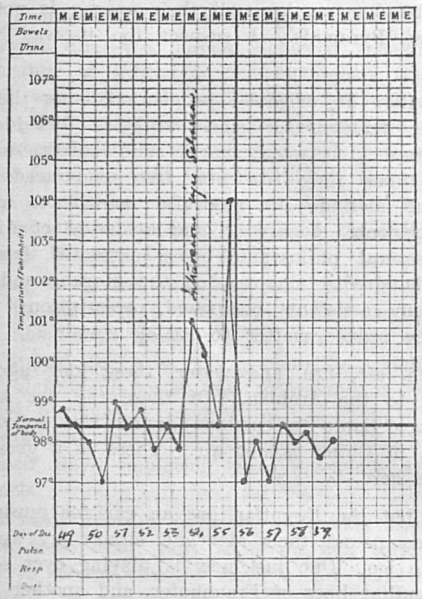
Third.—As Dr. French pointed out the exacerbations of temperature in the case were far less regular than is the general rule.

For these reasons I was not inclined to think the case was one of rat-bite fever at all. It was, however, as proved by the rapid cure following the injection of 606.

The other case in the district, following a bite from a kitten, had three injections of 606, but no doubt the infection was a more severe one than in my case.







Sir Thomas Horden, I think, looks upon the infection as due to a spirochæte, and he pointed out how cases of rat-bite fever resemble an attack of syphilis, in incubation period 21 to 28 days—original sore or bite—secondary rash—with relapses and cure with 606?

The charts enclosed will show the variations of the temperature and how unlike the chart of a typical case, as shown in French's Differential Diagnosis, page 598, is.

H. K. MITCHELL.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

The late Dr. A. S. Taylor.

DEAR MR. EDITOR,—The letter in your last issue from Mr. Fagge, has stirred me to write of the late Dr. A. S. Taylor as a rugby full back. Of his other athletics I know nothing.

He played for Cambridge in 1879—80—81, and represented England four times, twice in 1883 and twice in 1886. He would undoubtedly have done so many more times if he had allowed football to interfere with his work. He could, in the opinion of many judges of football, be classed amongst the four or five best full backs who ever played for England.

I well remember him on the last occasion when he played against Wales, at Blackheath, bringing down that remarkable dodger A. J. Gould, time after time, and his play that day was a large factor in England's win.

A tall wiry man, he was a stylist and took no liberties with what was then rigidly considered the orthodox game of a full back. He never passed on his own goal line, or took flying kicks at the ball, which we old stagers have shuddered to see of late years.

He was a fine fielder and kicker, but his tackling was quite exceptional and as deadly as any man I have seen. He always took his man below the waist and had a spring like a panther which made him impossible to dodge. He must have had extraordinary pace for ten or fifteen yards and seemed to gather himself together and shoot at his man, who was not merely held or stopped, but was crumpled up. I saw him play four or five times, but never saw a man get by him.

A quiet modest man, he was, as Mr. Fagge says, good to look at and good to be with—but he was a revelation as a full back.—Yours,

A. ALLPORT.

9, Charles Street,
St. James's Square, S.W. 1.
July 4th, 1921.

Suggested improvements for the Gazette.

DEAR SIR,—You ask (page 238) for suggestions for making the GAZETTE more popular. May I speak for your many readers who are G.P.'s.

When I was at Hospital, *The London Hospital Gazette* always published the Clinical Lecture on the four central pages, this was left loose. They could be than all gradually collected and bound together, making a most useful book. The Guy's Clinicals are I am afraid almost all lost. To-day there are two very good lectures which I should like to take out.

Often they start on the wrong side of the page or do not end anywhere easily cut out (such as lecture on page 204). Many years ago I put this point before the Editor, but as nothing was done I suppose it is not possible, but if *London* can do it why not we?—Yours truly,

C. THOMSON.

Romansleigh,
Wimborne,
June 28th, 1921.

The Biennial Dinner.

DEAR SIR,—I have no hesitation in asking you to find space for an item of interest to all Guy's men. As you have already announced, it has been decided that the Biennial Dinner shall take place

on Wednesday, October 26th, at the Connaught Rooms. Mr. Montagu Hopson will preside, and the following Guy's men have accepted an invitation to act as Vice-Chairmen on that occasion. The names are arranged in order of seniority of qualification, from 1878 to 1918:—E. Clifford Beale; H. G. Ashwell, O.B.E.; Col. C. H. L. Meyer, I.M.S.; Astley C. Roberts; Sir Alfred Fripp, K.C.V.O., C.B.; F. G. Swayne; W. H. Fisher, O.B.E.; F. J. Steward; C. D. Edwards, M.C.; E. B. Dowsett, D.S.O.; H. W. Bruce; E. W. Rowlands; A. E. Rowlett; H. V. Bagshawe, C.B.E., D.S.O.; E. Bellingham-Smith; A. Alcock; L. L. C. Reynolds, D.S.O.; G. T. Mullally; A. J. McNair; P. Smith, M.C.; A. C. Hancock, M.C.; J. P. Jones, M.C.; H. Millett.

The same plan will be adopted as in previous years; each Vice-Chairman will preside over a separate table and those coming to the Dinner will have an opportunity to indicate at whose table they would prefer to sit, thus assuring that, as far as possible, old friends can sit near each other.

The list given above is an ample guarantee that the Committee may look forward to receiving as valuable help from the Vice-Chairmen as on the last occasions.

The charge for the dinner will be 15s. exclusive of wine.

I earnestly ask for the help of all Guy's men, hoping that they will write and ask their friends and colleagues to bear in mind the date of October 26th, so that we may make the Dinner an even greater success, if possible, than in any previous year.—Yours sincerely,

ARTHUR W. ORMOND.
Hon. Secretary.

7, Devonshire Place, W. 1.
June 29th, 1921.

MOST INTIMATE SIR,—Here I am. My friends persuaded me to accept the chair of Alchemy in the City of the Prophets, but it profits me but little. I who am Chinese by birth and by sentiment find myself languishing here beside these Pyramids. I join with your walrus and your carpenter friends of little Alice, who wept to see such quantities of sand. Do you want any sand at Guy's? There is a very great deal of it here which, as far as I can see, is in the way. The camels lie in it, but I have not heard that it did them any particular good. I could easily make arrangements to send any of the staff as much sand as they require.

I have not seen any of what the physicist calls kinetic energy in this country. My theory is that when the Egyptians built the Pyramids they did so as a compromise with the Gods that work should never be done again. All their energy is potential in these Pyramids. I suspect too it was foreign labour.

But they are cheerful people. This is their redeeming feature, for since work is forbidden by the Prophet between sunrise and sunset, and at other times they feast or fast, one needs their cheerful attitude to reconcile oneself to getting nothing done. I have an ancient hostel of Alchemy with several philosophic books extracted from the Eight-hundredth Chapter of the Koran, and from these my assistants compound prescriptions whereby they reduce matter to its elementals.

Earth, air, fire, and water, these long ago were known to the Arabian. Of these the fire and air are very liable to combine giving rise to what is known in China as hot air. There is a great deal of this here.

Ah; but the Egyptian has an ear for music! As they compound their alchemic elixirs my assistants sing to me. One just now is playing over some of the familiar lines of Fraunhofer, and another accompanies him with the symbols. What a tune! This is the translation from the Arabic. Doubtless it has suffered much by translation:—

The Nile is nigh all H_2O,
Its sandy sides SiO_2.
And all the hot air we supply
Is N and O and CO_2.

Yes, all that we can hope to do,
From out the N to choose the O,
And to contribute CO_2,
Because that Allah willed it so.

And in the end ere there is time
To say heigh ho or sigh Oh too,
We shall return to — CaO,
SiO_2 and CO_2.

And I reply—

Ah, yes, if they could see at Guy's
This heaped up hot SiO_2,
My friends would truly Sympathise
And drop for me a Sigh or two.

I am, in all humidity,
HO HO.

Near the Pyramids, Egypt.
June 11th, 1921.

[We trust that HO HO will forgive us for the reply, which we publish below, to his very welcome letter, and will not, because of it, cease sending us his most interesting accounts of his life in the Near East.—Ed.]

HO HO,

Professor of Alchemy, Egypt.

Illustrious Sir,—We, having achieved the dignity and plurality of Editor of the fortnightly GAZETTE produced with laborious regularity at the Hospital of the great Guy, hasten to acknowledge your much esteemed letter. We regret deeply that you have not found to your celestial liking, the physiographical conditions of that ancient and revered seat of learning where now you teach the black art of alchemy to your dusky disciples.

You ask us do we want any sand here at Guy's? Strange to say only a few days before the advent of your auspicious epistle we had overheard a despairing appeal for this very commodity which you in your alchemical hostel find so redundant. Sand is wanted to make a sandpit in the Park so that the convalescent infants from the Baby Ward may spend their days emulating your ingenuous friends the camels.

If you will arrange to send us weekly consignments of fresh sand, post free, we will endeavour to raise a subscription to have a pit constructed which shall be worthy of your silicious offering. We are fired with enthusiasm for this scheme! We will call it the Ho Ho Hole for Homesick Howlers! So your illustrious name will go down to posterity as that of one of the greatest benefactors of the Hospital. When we think of Gordon and his museum, of Pavy, his gymnasium and his solution, we will not forget Ho Ho, who far across the seas heard the howling of the howlers and sent us sand that it might fill their mouths and hush their cries. Neither will the youngsters forget Ho Ho as they lazily lie building their castles in the sand. Neither will the handmaiden, whose duty it is to wash these children and to keep them clean, forget Ho Ho.

The lowly editorial intellect was long puzzled to find a meaning for the mystic letters, O.H.H.S., which appeared together with a frieze of characters in the Arabic above the superscription on the cover of your epistle. We had almost called in the interpretive services of one of those who belong to the race of the Pharaohs who study here the art of healing, when it dawned upon us that in your new home, that homage was paid you which we in England keep for His Majesty himself. It is very meet that all your professional correspondence should be marked On Ho Ho's Service, so that all who see your mystic sign may know they look upon the writings of the great alchemist. So may they all make their reverent and lowly kowtow as we do now.—Humbly we subscribe ourself, yours most unworthily.

OH OH.

Down in the Borough.
July 4th, 1921.

Landon Out-Patient Tea Fund.

STATEMENT OF INCOME AND EXPENDITURE
FOR THE YEAR ENDED MARCH 31ST, 1921.

INCOME.	£	s.	d.
To Donations and Collections (as per List)...	99	17	2
„ Interest on Invested Funds :—			
5% Exchequer Bonds ... 7 0 0			
Deposit Interest 2 16 4			
	9	16	4
Total Income	109	13	6
„ Excess of Expenditure over Income ...	28	13	6
	£138	7	0

EXPENDITURE.	£	s.	d.
By Cost of Tea, Groceries, Provisions, Fruit, etc.	49	9	9
„ Gifts of Toys, Clothing, etc.	53	8	10
„ Police Fees, Gratuities, etc.	24	0	0
„ Printing, Stationery, Postages, etc. ...	5	3	5
„ Decorations, etc.	6	5	0
Total Expenditure	£138	7	0

BALANCE SHEET, MARCH 31ST, 1921.

LIABILITIES.	£	s.	d
To Accumulated Funds:—			
Balance brought forward from last Account	301	7	6
Less Excess of Expenditure over Income for 12 months to Mar. 31, 1921	28	13	6
	£272	14	0

ASSETS.	£	s.	d.
By Investments :—			
£200 5% Exchequer Bonds at cost ...	200	0	0
„ Cash at Bankers :—			
On Deposit Account ... 70 0 0			
Current Account 2 14 0			
	72	14	0
	£272	14	0

Audited and found correct,
W. J. CURRY,
16th June, 1921.

F. A. SHELDON,
Treasurer,
Landon Tea Fund Committee,
Guy's Hospital Trained Nurses' Institution,
14, St. Thomas's Street, S.E.1.

Abstracts of Current Medical Literature.

Influence of Diet in Gastro-Intestinal Infections. —. McCarrison (Indian Journal Med. Research, Special Indian Science Congress Number, 1920) propounds two theses:—(i.) The freedom of the gastro-intestinal tract from infection depends upon the health of the gastro-intestinal mucosa; (ii.) Bad or insufficient food is the most ready means of inducing gastro-intestinal ill-health. The author quotes experiments upon monkeys, and clinical cases to prove these points, and shows the importance of a study of the dietetic history in these cases.

Pleurisy. (*Practitioner*, July, 1921.)

Sir W. Hale-White discusses some of the symptoms of pleurisy. Pain, due to various other causes, may lead to a wrong diagnosis.

In dry pleurisy the chest should be strapped. Where there is fluid free movement should be allowed. Seventy-five per cent. of serous effusions are tubercular in origin. The author makes a few brief observations on the auscultatory signs of fluid in the chest. Blood-stained fluid is due to T.B. or new growth.

Seventy-five per cent. of empyæmata are pneumococcal. Empyæma may be cured by the patient coughing up pus. X-rays are of little use in diagnosis. If the empyæma cannot be found, the chest should be opened by a surgeon.

Albuminuria. (*Practitioner*, July, 1921.)

F. G. Chandler shows that albuminuria does not necessarily indicate nephritis, and makes a survey of conditions in which albuminuria occurs.

Cardiology, Old and New. (*Practitioner*, July, 1921.)

Gordon Lambert discusses the foundations upon which modern cardiology rests and the results achieved. The discovery of the Nodal System, and the application of the ink polygraph by Sir J. Mackenzie to heart problems, have been instrumental in effecting these advances.

The author passes from a consideration of the functional anatomy of the heart to that of cardiac irregularities.

Response of Circulation to Low Oxygen Tension (Archives of Internal Medicine, Amer. Med. Assn., May 15th, 1921.)

Green and Gilbert discuss the application of electrocardiographic methods to this problem. Progressively induced oxygen deficiency produces slight and compensating changes up to a certain critical stage. After this there are (1) Decrease in the P.—R interval, (2) Decrease in the R.—T. interval, (3) Increased amplitude of the T. wave, and other changes which are fully discussed.

Injuries of the Diaphragm. (*Lancet*, July, 1921, Hunterian Lecture, abridged.)

Gordon Bryan discusses the early and late effects of injury to the diaphragm, and concludes that for strangulation and acute obstruction in diaphragmatic hernia the abdominal route should be employed in operative treatment. For chronic cases he advocates the thoracic route. In cases of special difficulty the incision may be enlarged and an abdomino-thoracic operation performed.

Hæmaturia as seen by the Surgeon. (*B.M.J.*, June 25th, 1921.)

Andrew Fullerton discusses and classifies the diseases in which hæmaturia may be present, and shows the importance of cystoscopy in diagnosis. He groups the cases into those affecting the kidney, ureter, bladder, prostate, and urethra. In treatment, the author recommends rest and morphine, if the latter is not contra-indicated in severe cases. The radical treatment of "essential" renal hæmaturia by removal of the organ is discussed. Irrigation of the bladder with silver nitrate, transfusion, and pressure in the perineum, (for hæmaturia from the bulbous urethra) are referred to.

Retrograde Catheterization for Impervious Stricture of the Urethra. (*Ibid.*)

W. J. Foster recommends combined retrograde and forward catheterization until "metal to metal" contact is obtained. He claims that this method has advantages over Wheelhouse's operation.

Schick Reaction. (*Ibid.*)

G. Ward explains the technique of this test and the interpretation of the reaction. From tests performed on large numbers of children the conclusion is formed that the most susceptible age is from six months to six years. The test is considered to be of value in diphtheria carriers and in estimating the susceptibilities of doctors and nurses engaged in attending to diphtheritic patients.

Abortive Treatment in Gonorrhœa. (*Practitioner*, June, 1921.)

W. Bayley is in favour of the Ballerger "sealing-in" method, combined with anterior irrigations. The

technique, by which he seals in collosol silver, alternating with anterior irrigations of Pot. Perman. 1/3000, is fully described.

Vaccine Therapy in Gonorrhœa. (*R.A.M.C. Journ.* June, 1921.)

Capt. J. S. K. Boyd compares 200 cases treated with vaccines of gonoccocci and staphylococci, with 200 control cases. Special attention is paid to the percentage of complications. The author concludes that there is no evidence that the treatment is of proved value.

American Journal of Surgery, Special Fracture Number, May, 1921.

This contains an excellent chapter on Intertrochanteric Fracture of the Femur by Speed, and, among others, several articles on fractures at the ankle.

Reviews.

Letters to a Nurse. By a Midland Doctor. (Messrs. John Bale, Sons, and Danielsson, Ltd.) Price 5s. net.

In these letters, written by a doctor to his niece during her training at a London hospital, the writer endeavours to assist her through some of the difficulties which she meets. Some sound advice is given concerning temperature charts, and pulses, and there are very interesting letters describing the effects upon the patients of diseases of the heart, lungs and kidneys.

In another the Out-Patients are recommended to the nurses sympathies, whilst in yet another the subject of theology in the wards is discussed.

Nurses would do well to read and act upon the advice in general given to his niece by "Uncle Luke."

Surgical Ward Work and Nursing. By Alexander Miles, M.D., F.R.C.S.Edin. Fourth Edition, 1921. (The Scientific Press Ltd.) Price 10s. 6d.

The fourth edition of this little handbook is very welcome and will be found useful by nurses.

The chapters on Ward Dressings, Post-Operative Treatment, and Complications are excellent.

The work is copiously illustrated, but two illustrations are not referred to in the text (notably Carrel Dakin tubes) and the illustrations of the granny and reef knots are incorrectly designated. Amidst such a galaxy of illustrations of instruments it is not surprising to find a few out of date, such as Luy's Separator, which is in error labelled Lean's Segregator. The chapter on splints is briefer and not up to the standard of the earlier chapters.

The handbook will be valued by nurses, both for ward and theatre duty.

Hints to Pensioners on the Home Treatment of D.A.H. By Francis Heatherley, F.R.C.S. (Messrs. C. Tinling & Co., Liverpool.)

In this small pamphlet, Mr. Heatherley has set out to help those pensioners who are suffering from D.A.H. He does this by destroying the bogey of heart disease which is always frightening these men. He explains that their hearts are not diseased, but only temporarily out of the perfect control of their nervous system. He goes on to give a rational explanation of various subjective symptoms, and points out the reasons for various measures which are adopted in the treatment of D.A.H.

The whole brochure is full of entertaining similes and of thorough good sense. There are tips here for every sufferer from D.A.H., whether his troublesome symptom is indigestion or insomnia, palpitation, or only that tired feeling. The patient is persuaded by explanation and encouragement to persevere with the simple measures which will ultimately bring about his cure.

If only every pensioner will read this pamphlet, and while laughing over its similes, will yet take its lessons to heart, the cure of D.A.H. will be made in the future easier and surer.

The Extra Pharmacopœia. By W. Harrison Martindale, Ph.D., F.C.S. and W. Wynn Westcott, M.B.Lond., D.P.H. Vol. II., Seventeenth Edition. (Messrs. Lewis & Co., London. 1921.) Price 17s. 6d. net.

Martindale and Westcott's Extra Pharmacopœia has earned for itself, by its conciseness and its completeness, a place in the library of every chemist, of every pharmacist, and of every physician. It presents to us a summary of all the new work on pharmacy, physiological chemistry and therapeutics, and by constant revision is kept well up to date by its compilers. The second volume of the seventeenth edition has now been published and serves to round off the work begun in this edition of the first volume, which appeared last June. The book has been much enlarged (it is more than half as large again as the corresponding volume of the sixteenth edition) and each section has been revised or rewritten in the light of the latest opinions. It would be impossible to call attention to all the divers additions, but the following comments must serve as an indication of the general thoroughness of the revision.

Under Acid Aceto-Salicylic, a recently discovered quantitative test for aspirin is explained. Under Calcium, mention is made of the various processes of fixation of atmospheric nitrogen, and of the great use these processes proved to the Germans during the war. Later there comes a short summary of the recent work on the accessory food factors, then a section on organotherapy and a discussion of advances in radiology and radium therapy. Notes are given of several new tests to be employed in clinical chemistry which may prove to be of great use (for instance under tests with the cerebro-spinal fluid there is given a chemical test for meningitis). Lastly we have an exhaustive summary of the newer work on bacteriology.

The whole is written in an interesting, even engrossing, style, which is rarely found in books on pharmacy. It is well arranged, so that even without the aid of the excellent index, with which the book is provided, reference would be an easy matter.

It is of interest to note that the authors throughout express themselves very satisfied with British drugs, which have, in their opinion, come to surpass the much-vaunted foreign medicaments of pre-war days.

A Textbook of General Pathology. Second Edition. By J. M. Beattie, M.A., M.D., and W. E. C. Dickson, M.D., B.Sc. Price 31s. 6d. net.

A second edition of this well-known textbook of pathology has recently been published. The book has been largely rewritten and much new work has been included, notably a chapter on "Fever," in which is summarised the work which was done during the war on the lesser known causes of pyrexia. The new edition contains many fine micro-photographs and coloured plates and shows great improvement upon the first edition. One feels, however, that too much space is still devoted to the chapter on the various animal parasites. Most of these are rarely met by the average practitioner, and they do not seem of sufficient importance to justify the devotion of a hundred pages to their study in a book which contains less than five hundred pages altogether.

Notices.

Social Work amongst Adolescents.

Dear Sir,

I am venturing to write to you in connection with a piece of social work in the Southwark district which may appeal to some of the students at Guy's and to ask if you will be kind enough to allow my letter to appear in the Hospital GAZETTE.

The Bishop of Southwark's Committee for work among Adolescents is interested in a large hall which has been offered for Club premises; it is in good condition and is known as the Red Cross Hall, just off Southwark Street.

Most certainly the district has need of such a club and there will be no difficulty in filling it; nor, I believe, is money likely to be the difficulty; we have some backing including some undergraduates of Emmanuel College, Cambridge.

If we are to open this Club in a successful way next October it will be necessary to have some sound men to help in the evenings.

I would like to ask that some of the Hospital Students should give some of their time and energy to this scheme.

May I, Sir, through you, give an invitation to any who may feel interested to write to me and ask to have a look at the place, for I would like to have the chance of showing the hall to them.

There is at the hall one room which would make an excellent Common room for men who might want to do a bit of reading in the evenings before the club opened.

I apologise for so long a letter.

Yours etc.,
S. G. HOOPER,
Bishop's Chaplain and Hon. Sec. of Committee.
Bishop's House,
Kennington Park, S.E. 11.
July 5th, 1921.

Golf.

The Staff v. Students Match was played at Sundridge Park on Wednesday, June 1st, under ideal conditions. The result was entirely satisfactory for both sides.

Results.—Matches won, 4; matches lost, 4; matches squared, 4. The whole match being halved.

STAFF.		STUDENTS.	
Mr. Bromley (3 & 1)	1	C. M. Stuart	0
Dr. Hurst	0	C. Gill-Carey	1
Dr. Cameron (3 & 2)	1	Hooper	0
Mr. Malleson (1 up)	1	Whitlock	0
Mr. Mollison (2 up)	1	Coysh	0
Mr. Davies-Colley		Wood, all square.	
Mr. Johnston		Crook, all square.	
Dr. Ryffel	0	Fouché (1 up)	1
Mr. Fagge		Smith, all square.	
Dr. Fawcett		Hodgkinson, all square.	
Mr. Hughes	0	Shaw (2 & 1)	1
Mr. Rowlands	0	Schofield (5 & 3)	1
	4		4

Inter-Hospital Athletic Sports.

The Annual Meeting was held on Tuesday, June 28th, at Queen's Club. The attendance was very disappointing, only two or three hundred people being present from seven competing hospitals.

From an athletic point of view, however, some very good performances were put up. The outstanding achievement being that of R. C. Lightwood (King's College Hospital), who won the three miles, one mile, and half mile challenge cups, and was chiefly instrumental in the success of King's in the relay race, which was instituted this year. His success in this latter, the last event of the day, gained the Shield for King's College Hospital by the narrow margin of 4 points. C. L. Steyn (Guy's) won the 100 yds. and 220 yds. events. R. Salisbury Woods (St. George's), broke the record in "Putting the Shot," with a distance of 40ft. ½in. J. C. Ainsworth Davis (St. Bart.'s), besides winning the 440 yds., put up a great fight for the relay event, success in which would have taken the Shield to St. Bartholomew's Hospital.

At the conclusion of the Sports Viscountess Goschen kindly presented the prizes. We were delighted that she was able to be present, and only bewail the fact that so few were able to stay for the Presentation. Dr. Voelcker, the President, who has been associated with the Club for over 40 years, concluded the proceedings with a vote of thanks to Viscountess Goschen.

Results—

100 *Yards.*—C. L. Steyn (Guy's), 1; J. C. Ainsworth-Davis (St. Bart.'s), 2. Time, 10 1-5 secs.

220 *Yards.*—C. L. Steyn (Guy's), 1; J. C. Ainsworth-Davis (St. Bart.'s), 2. Time, 22 4-5 secs.

440 *Yards.*—J. C. Ainsworth-Davis (St. Bart.'s), 1; W. L. Ackerman (London), 2. Time 53 4-5 secs.

880 *Yards.*—R. C. Lightwood (King's), 1; A. S. Gough (Guy's), 2. Time, 2 mins. 5 4-5 secs.

One Mile.—R. C. Lightwood (King's), 1; L. G. Housden (Guy's), 2. Time, 4 mins. 46 2-5 secs.

Three Miles.—R. C. Lightwood (King's), 1; L. G. Housden (Guy's), 2. Time, 16 mins. 6 4-5 secs.

120 *Yards Hurdles.*—J. R. Banks (University), 1; P. K. Albertijn (Guy's), 2. Time, 17 2-5 secs.

High Jump.—J. D. Allen (St. Bart.'s), 1; J. R. Banks (University), 2. Height, 5ft. 5ins.

Long Jump.—L. B. Cole (St. Thomas'), 1; H. J. McCarthy (London), 2. Distance, 21ft. 11¼ins.

Putting the Shot.—R. Salisbury Woods (St. George's), 1; R. D. Reid (St. Bart.'s), 2. Distance, 40ft. ½in. Record.

Throwing the Hammer.—S. H. G. Humphrey (St. Thomas'), 1; B. R. Crossley (University), 2. Distance, 98ft. 7ins.

One Mile Relay Race.—King's College Hospital, 1; St. Bartholomew's Hospital, 2. Time, 3 mins. 57 1-5 secs.

Points towards Shield.—King's, 40 points, 1; Guy's and St. Bartholomew's, 36 points each, 2.

Officials—Judges.—W. H. Brooker, Esq., H. J. Barclay, Esq., Gordon C. Innes, Esq., Lt.-Col. F. Nicol.

Time Keeper.—J. E. Fowler Dixon, Esq.

Starter.—Alec. Nelson, Esq.

Guy's Nurses' Swimming Club.

The Swimmers are not to be outdone by the Tennis Players. On Friday, July 1st, at the Bath Club, the nurses added another cup to their collection. Sir Alfred Fripp generously offered a Nurses' Inter-Hospital Silver Challenge Cup, and for some weeks past, the nurses of the various London hospitals have been working very hard to improve their swimming.

On June 14th heats were swum off in the Shoreditch Baths, both Guy's and University College beating the King's College team. Great consternation was caused when the fact was announced that University College was having special coaching and hoped to do well. However, our nurses were favoured with a visit by Lady Fripp, who helped them a great deal, and Mr. Jarman also came to the swimming practices several times to give "tips."

At the Bath Club our team were in very good form; in the 50 yards Flat Race Nurse Garland (Guy's) won an easy 1st; Nurse Oliver (University College) 2nd, and Nurse Pickard (Guy's) came in 3rd.

The Team Race also went well. The Guy's representatives were:—Nurses Banks, Burvill-Holmes, Garland, D. G. James, K. Pickard and Sheppard, and they won handsomely by one length.

We hear that there are already entries from other London hospitals for next year, so we must continue to work, and hope to keep the Cup.

Although this is the first year that Guy's nurses have entered for an Inter-Hospital Swimming Cup, it is not the first year that they have been allowed to swim in public. It will be remembered that before the war the nurses used to take part in the Students' Swimming Sports which were held in the Southwark Baths.

Thanks for the enterprise and confidence displayed by our Matron in this matter were duly rendered by the President at the Distribution of Trophies by Lady Wavertree.

United Hospitals' Swimming Club.

The Gala Night was held before a distinguished assembly at the Bath Club (by kind permission of

the Committee of the Bath Club), on Friday evening, July 1st. The President, Sir Alfred Fripp, in the chair. From the commencement, the interest of the crowded audience never lagged.

Guy's are to be congratulated upon the exceptionally good display they put up, winning three cups and tieing with London Hospital for the fourth. The nurses were to the fore in some very good swimming, especially Nurse Garland, of Guy's, whose skill was admired by everybody present. E. T. Crosoer, of Guy's, is to be congratulated on his magnificent plunge, and W. E. Silver, also of Guy's, for his splendid diving. The Water Polo match between St. Bartholomew's and Guy's was more or less a walk over for the latter, who won 8 goals to nil. The swimming was extraordinarily even, London winning the 25 yds. and 50 yds. and Guy's getting the 100 yds. and team race.

Praise and thanks must also be given to the members of the Amateur Diving Association, who gave such a wonderful display of fancy diving; also to the members of the Otter and Wandsworth Swimming Clubs, who had kindly consented to play their League Water Polo match, which was the most exciting event during the evening.

At the close of the evening Lady Wavertree, C.B.E., kindly gave away the cups and prizes amidst general applause. The President thanked the Bath Club for being so good as to allow us to have the Bath, the Matrons for allowing their nurses to compete, the officials for their kind attendance and work as judges, starters and time-keepers, and Lady Wavertree for her kind consent to present the prizes. He commented upon the success of the entertainment, paying special tribute to the A.D.A., the Otter and Wandsworth Water Polo match, and the Nurses' Swimming Display.

Results—

INTER-HOSPITAL DIVING CUP.

Plunge.—E. T. Crosoer (Guy's), 1; P. G. Harvey (Guy's), 2; W. J. Fenton (London), 3. Distance 60ft. 9ins. Points: Guy's 8, London 0.

Diving.—W. E. Silver (Guy's), 1; L. W. Wilson (London), 2. Points: Guy's 10, London 4.

Points for the Cup—Guy's 18, London 4.

INTER-HOSPITAL SWIMMING CUP.

One Length.—H. W. L. Molesworth (London), 1; F. G. Hutchinson (Guy's), 2. Time, 13 1-5 secs.

100 *Yards.*—R. Jarman (Guy's), 1; L. W. Wilson (London), 2. Time, 70 1-5 secs.

50 *Yards.*—H. W. L. Molesworth (London), 1; O. F. Painter (Guy's), 2. Time, 30 1-5 secs.

Team Race.—Guy's, 1; London, 2. Time, 82 3-5 secs. Won by a length.

Points for Cup—London and Guy's 28 points each.

INTER-HOSPITAL NURSES' SWIMMING CUP.

50 *Yards.*—Nurse Garland (Guy's), 1; Nurse Olivier (U.C.H.), 2.

Team Race.—Guy's, 1; U.C.H., 2. Won by a length.

Points for Cup—Guy's 20, U.C.H. 8.

INTER-HOSPITAL WATER POLO CUP.

Won by Guy's, 8 goals to nil.

Final of One Length Handicap.—F. Jory, 1; G. B. Kempster, 2; S. T. Hine, 3.

Final of Two Lengths Handicap.—F. Jory, 1; N. Penreath, 2; G. B. Kempster and R. Jarman tied for third place.

Final of Three Lengths Handicap.—W. E. Silver, 1; S. E. Theis, 2.

Final of Two Lengths Back Race.—O. F. Painter, 1; P. G. Harvey, 2.

Display by members of A.D.A.

League Match between Otter and Wandsworth Swimming Clubs.—Otter S.C. won, 5 goals to 2.

The President and Committee wish to thank the Governors of Guy's Hospital for the handsome Diving Challenge Cup they have given to the Club, and also wish to thank the many members of the QStaffs of large Hospitals.

Lawn Tennis.

The Semi-Final of the Inter-Hospital Cup was played against London Hospital at Honor Oak Park, on June 22nd, 1921, and we won by 10 matches to 2, and 3 being unplayed.

In the singles Jackson won in straight sets against their first man. Jacobsz, who played second, had a very hard match and only won in the final set 12—10. Nurick found great difficulty in beating his man, who started off in great style. He improved towards the end and won the last set with the loss of only 3 games. Albertijn played his usual steady game and won his match quite easily. Keyter struck good form and had his opponent guessing all the time. His terrific forehand drives being untakeable at times. Neser played an uphill game and after a hard fought match managed to win in the final set.

Jackson beat Evans, 6—1, 7—5; Jacobsz beat Petersen, 6—4, 4—6, 12—10; Nurick beat Petersen, 15—13, 2—6, 6—3; Albertijn beat Cairns, 6—3, 6—3; Keyter beat Love, 6—3, 7—5; Neser beat Franks, 7—5, 4—6, 8—6.

In the doubles Jackson and Daneel beat Evans and Cairns, 6—4, 4—6, 6—2; beat Petersen and Petersen, 6—4, 6—2.

Nurick and Jacobsz beat Petersen and Petersen, 6—4, 4—6, 10—8; lost to Franks and Love, 6—3, 6—2.

Keyter and Neser beat Franks and Love, 6—4, 4—6, 6—4; lost to Evans and Cairns, 6—4, 6—2.

GUY'S v. EASTBOURNE.

On Saturday, July 2nd, Guy's played Eastbourne Lawn Tennis Club at Eastbourne. We were at full strength.

The match started at 3 o'clock, conditions being perfect. There were a large crowd of spectators.

In the opening round Jackson (Capt.) and Daneel lost their first match as they could not settle down. In the second and third matches they found their form and managed to win comfortably. Daneel was smashing with great effect and from almost any position on the court.

Jacobsz and Nurick could not get going and lost two out of three matches. They beat their first couple in a convincing style. Jacobsz was very severe overhead, but was inclined to take too much, with the result that he and his partner were often out of position.

Keyter and Albertijn started in great form and found no difficulty in winning all three matches without the loss of a set. Keyter's drives were very hard and finely placed, and Albertijn was faultless overhead. They were frequently applauded for their fine combination.

Result—Guy's won 6—3.

Inter-Hospital.

GUY'S "A" v. BART.'S "A."

Semi-Final Junior Tennis.

On July 3rd, at Winchmore Hill, Guy's "A" beat Bart.'s "A" in the Junior Tennis by 11 matches to 1, three being left unplayed.

In the singles we won 5 matches to 1, Dingley of Bart.'s beating Gordon. Schollum had a hard game with Miller of Bart.'s, but the others were rather one-sided matches.

We won all the doubles played.

Scores appended:—

Singles:—B. L. Laver beat B. Gibson, 6—0, 6—0; Lewis Phillips beat C. Stuart Low, 6—3, 6—4; V. Morgan beat K. Loveday, 6—2, 6—4; J. W. Schollum beat H. Russell, 6—1, 3—6, 6—4; R. Schlummer beat J. Joule, 6—3, 6—3; A. Gordon lost to R. Dingley, 3—6, 4—6.

Doubles:—

Laver and Becker beat Stuart Low and Loveday, 6—3, 6—4; beat Gibson and Russell, 6—4, 6—0.

Schollum and Gordon beat Gibson and Russell, 6—3, 3—6, 6—2; beat Joule and Dingley, 6—4, 6—2.

Phillips and Morgan beat Joule and Dingley, 6—1, 9—7; beat Stuart Low and Loveday, 6—0, 6—4.

Guy's Hospital Rifle Association.

The third shoot for the Armitage Cup was held on Wednesday, 22nd June. The following were the scores:—Beamish, 95; Bingay, 89; Barnes, 86; Weinbren, 82; Foy, 80; Elkington, 74.

Inter-Hospital Prize Meet, Bisley, 29th June.

The day was a glorious one, and it was a pleasing sight to notice the eagerness with which those who chose to spend the day on the ranges awaited the departure of the early train for Bisley to participate in what proved to be a most successful day for the Hospital.

Hardly had the shooting commenced when a strong wind sprang up, blowing directly across the range. Proficiency in the use of the wind gauges soon, however, enabled the competitors to find the mark with the desired results.

The first item was the fourth and last shoot by the Guy's team for the Armitage Cup, which has been retained with a total of 1,981, as against Bart.'s, who were second with 1,945, the scores for the final shoot being—Foy, 93; Bingay, 84; Barnes, 80; Beamish, 80; Elkington, 78, and Weinberg, 70.

The remainder of the Inter-Hospital events were then fired off: —

Armitage Cup, Inter-Hospital, won by Guy's.

Newton-Pitt Cup, "Guy's Challenge Cup, won by Mr. W. H. Foy (Guy's).

200 yards, Inter-Hospital, 1st Prize, won by Mr. W. H. Foy (Guy's).

500 yards, Inter-Hospital, 1st Prize, won by Mr. W. H. Foy (Guy's).

600 yards, Inter-Hospital, 1st Prize, won by Mr. R. J. A. Moore (Guy's).

1,000 yards, Inter-Hospital, 1st Prize, won by Mr. W. G. Elkington (Guy's).

300 yards, Snap Shooting, Inter-Hospital, 1st Prize, won by Mr. Irving (London).

300 yards, Rapid Shooting, Inter-Hospital, 1st Prize won by Mr. Jory and Mr. McMichael (Bart.'s).

Donegal Badge, Inter-Hospital, won by Mr. Elgood (Bart.'s).

Grand Aggregate, Inter-Hospital, 1st Prize, won by Mr. W. H. Foy (Guy's).

Grand Aggregate, Inter-Hospital, 2nd Prize, won by Mr. Elgood (Bart.'s).

Tyro's Prize, Inter-Hospital, 1st Prize, won by Mr. Hobson-Jones (Guy's).

Mr. Thompson's Prize, Guy's, 1st Prize, won by Mr. W. H. Foy (Guy's).

Handicap, Guy's, 1st Prize, won by Mr. Hobson-Jones (Guy's).

Inter-Hospital Sweepstakes—

200 yards, 1st Prize, Mr. W. H. Foy (Guy's); 2nd Prize, Mr. J. Bingay (Guy's).

500 yards, 1st Prize, Mr. Jory (Bart.'s); 2nd Pirze, Mr. J. Bingay (Guy's).

600 yards, 1st Prize, Mr. Elgood (Bart.'s); 2nd Prize, none.

1,000 yds., 1st Prize, Mr. G. W. Elkington (Guy's); 2nd Prize, Mr. W. H. Foy (Guy's).

200, 500 and 600 yards, 1st Prize, Mr. W. H. Foy (Guy's); 2nd Prize, Mr. Elgood (Bart.'s).

Spoon Winners amongst the Guy's men were:—Mr. Weinbren, 3; Mr. Beamish, 2; Mr. Foy, 2; Mr. Bingay, 1; Mr. Hallpike, 1; Mr. Mechelburg, 1.

Mr. Thompson and the Misses Thompson were present, the latter very kindly presenting the prizes to the successful competitors. This was done in the London and Middlesex Club.

Our hearty congratulations are extended to Mr. Foy in winning the Newton-Pitt Cup and for doing so well in the other events.

Cricket.

GUY'S v. ST. BART.'S.

Second Round Cup Tie.

This match was played at Honor Oak Park on 14th June, 1921, resulting in a comfortable win for this Hospital by 134 runs. Guy's batted first and thanks to excellent innings by Shaw and Willis, 93 runs were added before Shaw was caught at mid-off. Rose and Wooldridge batting very brightly, added 43 and 69 (not out) respectively. The Hospital declared with 5 wickets down for 326 runs.

Bart.'s failed to make the runs, being dismissed for 192. A. E. Parks and R. H. Maingot batted well for the visitors and looked like making a good fight when Parks was bowled by an excellent ball from Biddle, and shortly afterwards May stumped Maingot, off Wooldridge, after this Shaw and Wooldridge, the latter bowling very well, found little difficulty in dismissing the rest.

Guy's.

G. D. Shaw, c Parkes b Parris	49
L. C. Willis, b Parkes	80
A. G. Ensor, c Edwards b Cooper	13
S. Rose, c Gillfoyle b Cooper	43
T. Wooldridge, not out	69
L. B. Helder, lbw Maingot	15
G. L. Shearar, not out	33
Extras	24
Total (for 5 wickets dec.) ...	326

Did not bat: J. Van Schalkwijk, H. B. Cahill, F. J. Biddle, R. C. May.

Bart.'s.

H. B. Cooper, b Shaw	28
T. Parrish, b Biddle	4
A. E. Parkes, b Biddle	52
L. H. Oldenshaw, b Van Schalkwijk	2
R. H. Maingot, st May b Wooldridge	43
V. F. Farr, b Wooldridge	25
W. F. Gaisford, b Wooldridge	0
E. W. P. Davies, b Shaw	9
A. S. Edwards, not out	11
E. P. Guilfoyle, b Wooldridge	4
R. E. S. Smith, c Helder b Shaw	0
Extras	14
Total	192

Bowling:—J. Van Schalkwijk, 1 for 32; F. J. Biddle, 2 for 57; G. D. Shaw, 3 for 50; F. Wooldridge, 4 for 38.

GUY'S v. OLD CHARLTON.

Played at Charlton on Saturday, 18th June, 1921.

Old Charlton.

E. Punch, c Eglington b Biddle	5
L. Bishop, b Van Schalkwijk	2
A. Martin, c Biddle b Van Schalkwijk ...	1
J. Lambert, c Curle b Shaw	47
S. D. Frisco, lbw b Wooldridge	13
J. Sharman, c Rose b Wooldridge	39
F. Dennison, lbw b Wooldridge	1
E. H. Haslam, c and b Shaw	4

A. S. Gates, c Eglington b Wooldridge ...	1
P. G. Briggs, c and b Wooldridge	0
V. Baxindall, not out	0
Extras	15
Total	128

Guy's.

L. C. Willis, run out	19
G. D. Shaw, b Baxindall	6
S. Rose, b Baxindall	6
H. A. H. Harris, c Lambert b Baxindall ...	17
T. Wooldridge, b Baxindall	33
L. B. Helder, not out	61
G. L. Shearar, b Briggs	0
J. Van Schalkwijk, not out	6
Extras	12
Total (for 6 wickets)	160

Did not bat: G. Curle, D. Eglington, F. J. Biddle.

Bowling:—J. Van Schalkwijk, 2 for 21; F. J. Biddle, 1 for 37; G. D. Shaw, 2 for 37; T. Wooldridge, 5 for 18.

GUY'S v. BEDDINGTON.

Played at Beddington on Saturday, 25th June, 1921.

Guy's.

G. D. Shaw, c Harrison b Reay	9
S. Rose, c Bulfield b Reay	12
H. A. Harris, b Collins	22
L. B. Helder, c Harrison b Collins	1
T. Wooldridge, c Mason b Reay	7
G. M. Stuart, c Harrison b Hammond ...	24
G. L. Shearar, b Reay	3
J. Van Schalkwijk, b Collins	4
F. J. Biddle, b Reay	25
H. B. Cahill, b Harrison	1
R. C. May, not out	4
Extras	27
Total	139

Beddington.

H. T. Tovery, b Van Schalkwijk	11
J. C. Christie, c Helder b Stuart	61
T. R. Hammond, c Helder b Van Schalkwijk	55
L. E. Ress, not out	32
Extras	18
Total (for 3 wickets)	168

Did not bat: G. M. Reay, F. C. Harrison, R. S. Collins, R. W. Bulfield, T. Rothwell, F. C. Potter-Irwin, J. N. Mason.

Bowling:—J. Van Schalkwijk, 2 for 54; T. Wooldridge, 0 for 37; G. D. Shaw, 0 for 33; F. J. Biddle, 0 for 14; G. M. Stuart, 1 for 17.

GUY'S v. BICKLEY PARK.

Played at Bickley on Wednesday, 22nd June, 1921.

Bickley Park.

K. W. Douglas, c Eglington b Van Schalkwijk	10
D. A. Ackenhead, c Eglington b Van Schalkwijk	4
S. Platt, c Van Schalkwijk b Wooldridge ...	5
J. W. Willett, c Wooldridge b Van Schalkwijk	65
B. H. Tucker, c Eglington b Shaw	0
R. M. Veal, b Van Schalkwijk	19
G. L. Crowe, b Shaw	22
J. W. Mansergh, b Wooldridge...	43
R. F. Jennings, b Wooldridge	3
V. Crosse, c Shaw b Van Schalkwijk... ...	1
L. G. Jackson, not out	0
Extras	33
Total	205

Guy's.

L. C. Willis, b Douglas	8
G. D. Shaw, b Douglas	7
S. Rose, lbw b Ackenhead	17
L. B. Helder, b Crowe	27
T. Wooldridge, b Crowe...	31
A. G. Ensor, c and b Tucker	6
G. L. Shearer, b Jackson	44
J. Van Schalkwijk, c Crosse b Tucker... ...	24
G. Curle, c Platt b Tucker	6
D. C. Eglington, b Tucker	1
F. J. Biddle, not out	1
Extras	13
Total	185

Bowling:—J. Van Schalkwijk, 5 for 57; F. J. Biddle, 0 for 37; G. D. Shaw, 2 for 56; T. Wooldridge, 3 for 24.

GUY'S v. CATFORD WANDERERS.

Played at Honor Oak Park, on 29th June, 1921.

Catford Wanderers.

Mundy, c Shearar b Shaw	9
De Saules, c Wooldridge b Williams... ...	80
White, c Harris b Stuart	31
Webb, c Couch b Shaw	40
M. L. Langford, run out	34
Best, b Biddle	12
C. W. Langford, not out	25
Baker, run out	10
Extras	24
Total (Innings declared)	265

Did not bat: W. Cook, J. Miller.

Guy's.

A. G. Ensor, b Mundy	4
H. A. H. Harris, lbw b Miller	1
D. G. Eglington, c Webb b Langford ...	46
G. M. Stuart, lbw b Miller	7
T. Wooldridge, b Best	47
F. J. Biddle, b Langford	25
G. L. Shearar, b Langford	17
G. D. Shaw, b Langford	3

G. Curle, c De Saules b Langford	13
T. T. Williams, not out	8
T. Couch, not out	0
Extras	10
Total (for 9 wickets)	181

GUY'S v. ST. MARY'S.

Semi-Final Cup Tie.

This match was played at Winchmore Hill on 30th June, 1921, and resulted in a win for the Hospital by 4 wickets and 162 runs. St. Mary's batted first, Boobyer and Reason opening. Our bowlers were keeping an excellent length, and runs came very slowly, 20 only being scored in the first hour. Wooldridge relieved Shaw and was immediately successful, taking three wickets in his first over. A seventh wicket stand by Roberts and Jaggarsar put on 27 runs; the rest were dismissed without difficulty before lunch for 78.

Willis and Shaw opened for the Hospital, and 56 runs had been added before Shaw was bowled. Rose joined Willis, and the score reached 71 before Willis was dismissed. Helder and Rose then took the score past the opponents' total without further loss. Rose batted well for his 95 and was unfortunate in being caught and bowled in trying to force a drive. Schalkwijk, Shaw, Biddle, and Wooldridge were all bowling well.

St. Mary's.

P. W. Boobyer, c Van Schalkwijk b Biddle ...	14
E. L. J. Reason, c Wooldridge b Shaw ...	4
G. C. Oliver, b Wooldridge	3
R. M. Handfield-Jones, b Wooldridge ...	0
G. Williams, c Helder b Wooldridge	0
F. H. Leedham, run out	5
W. S. Roberts, lbw b Van Schalkwijk ...	15
W. A. Date, b Wooldridge	11
L. D. Jaggarsar, b Van Schalkwijk	17
R. H. Scott, b Shaw	6
J. W. Jeffrey, not out	2
Extras	1
Total	78

Guy's.

L. C. Willis, b Roberts	32
G. D. Shaw, b Roberts	28
S. Rose, c and b Juggarsar	95
L. B. Helder, b Handfield-Jones	15
T. Wooldridge, c and b Handfield-Jones ...	3
A. G. Ensor, b Date	26
G. L. Shearar, not out	27
Extras	14
Total (for 6 wickets)	240

Did not bat: J. Van Schalkwijk, F. J. Biddle, G. M. Stuart, R. C. May.

Bowling:—J. Van Schalkwijk, 2 for 19; G. D. Shaw, 2 for 8; F. J. Biddle, 1 for 20; T. Wooldridge, 4 for 30.

The Annual Cricket Match "Past" v. "Present" will be played at Honor Oak Park, on Wednesday, July 27th, at 11.30 a.m. Any old Guy's Man (and particularly those who have played in this match in the past), who is desirous of disproving that he is "shorter in wind as in memory long," is asked to communicate with G. P. Lindsay, at Lambeth Infirmary, S.E.1.

Specialities.

THE PROFITS AND INCOME INSURANCE CO., LTD., 9, FLEET STREET, E.C. 4.

Medical men, from their calling, are, perhaps, more liable to sickness than any other class, and they are certainly not less free from accidents.

A "practice" is a personal matter, and although when necessary, the services of a Locum are sought, such assistance incurs possible loss of patients, which means a loss of income.

In both cases the Profits and Income Insurance Co., Ltd., have provided for such contingencies by a system of Insurance, of which all Medical Men should take advantage.

Many Guy's men are already amongst the Policy Holders, and those who are not protected against the risk of loss of income, from sickness, or accident, cannot do better than apply to this Company for their Policy arrangements, or particulars, proposals, forms, etc., can be obtained from the GAZETTE Office, Counting House, Guy's Hospital, S.E. 1.

We have been asked to explain to our readers that in future the firm that manufactures the well-known Walton and Curtis Abdominal Belt will trade under the name of H. E. Curtis & Sons, Ltd.

Publications Received.

St. Bartholomew's Hospital Journal, The Stethoscope, Nursing Times, London Hospital Gazette, Prescriber, Charing Cross Hospital Gazette, King's College Hospital Gazette, the Serpent, St. Mary's Hospital Gazette, The Hospital, Report of Voluntary Hospitals Committee, Guy's Financial Report.

THE EDITOR will, at all times, be glad to consider articles or sketches, provided that they are accompanied by the writer's name and address, not necessarily for publication. The payment that the GAZETTE *can offer is merely nominal. Authors who desire reprints of their papers should make their own arrangements with the printers when they return their proofs. All contributions to be addressed to the Editor, "Guy's Hospital Gazette," Guy's Hospital, London, S.E.*

ED.—A. T. R.

GUY'S HOSPITAL GAZETTE.

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Passim.

THE splendour and the excitement of the garden party have passed and Guy's is settling down to its own drab self again. Only here and there brightly painted posts remind us of last week's gaiety. We are all glad that we have regained such a pleasant function as this proved to be, and we trust that no future year will be allowed to pass without its garden party. For an account of all that happened and of all that was said we refer our readers to the subsequent pages of this Gazette.

THOUGH we much regret that the Prince of Wales was unable to be present to unveil the War Memorial yet we are very gratified that the Duke of York found it possible to accept, at such short notice, the engagement which his brother had been forced to cancel. We were pleased to learn too that the Duke had graciously accepted the Governorship of the Hospital which was offered to him by a specially convened Court of Governors. Guy's is indeed honoured to have at once two Royal Princes on its Court of Governors.

AT present there is an unprecedented number of men doing the earlier clinical appointments. In consequence, each man has far fewer beds to look after than is usual, and so gets far less individual clinical experience. The Medical Ward Clerk who is doing his first three months clinical medicine now has only two beds to take care of, compared with the normal number of seven or eight. When one realises that it is quite possible that one or both of these beds may be occupied by some chronic case which, despite all treatment, hardly changes from one month to the next, it is obvious that the field for examination of cases by medical wark clerks is now vastly limited. True, the clerk goes round with registrars and physicians. But the amount he learns from the perfunctory examinations, which are all that is possible on such rounds, is infinitesimal compared with the knowledge gained by careful examination of his own cases in his own time.

The following scheme has been put forward as a possible remedy for this state of affairs. Let each bed be looked after by three clerks, each of whom makes his own examinations and writes his own report. Thus each clerk would have three times as many cases for whose reports he would be actually responsible. He would be impelled to examine his cases well, so that his report might be at least as good, if it could not be better, than the reports written by his colleagues. For naturally it would be the duty of the registrar to choose the best report of the three to be the permanent record

of the case. In this way the clerk would profit by increased experience and the Hospital would have a better series of reports.

There are, however, several disadvantages which must not be overlooked. Firstly, it would involve a triple examination of the patient, who even now often finds the ward clerk's attentions irksome. And even if we are to assume that the patient, in the interests of progress, will submit to repeated pommelling, we can still not be sure that clerks will make the most of this opportunity. It would be the easiest thing in the world for the slack man to avoid all his clinical work by merely writing paraphrases of the reports written by his colleagues. And the pity of it is, that, by so doing, he might easily produce a report better than either of the other two, and so gain undeserved kudos.

Nevertheless, we think that the scheme is worth consideration, and will be glad to publish the comments of those whom it most intimately concerns—the registrars and the ward clerks—if they will send us their opinions.

WE stated in our last *Passim* that Mr. Warner was the first Guy's man to win the University of London Studentship in Physiology. We find that this statement was untrue, and we offer our apologies to Mr. Frank Cook, who also won this Studentship.

DURING the last fortnight Guy's has fought for two more cups. One, the Junior Lawn Tennis, we won by beating University College Hospital by eight matches to two, the five other matches remaining unplayed. The other was the Cricket which we lost in the final round to St. Thomas's Hospital. After a long (two-day) match Guy's finished only 37 runs short of the score made by their conquerors.

WE have received a copy of the Hospital Financial Report for 1920, from Mr. Curry. This report shows that Guy's, like most of the other great London hospitals, is now no longer able to pay its way. This is due, not to a decrease in income, for we are receiving now larger contributions than in previous years. Almost entirely is it due to the increased cost of maintenance. The annual expenditure of the Hospital has risen from £73,000 in 1913 to £163,000 in 1920. Subscriptions to the Hospital have not kept pace with this rapid rise in the expenses, and so, in spite of a grant of £7,000 from King Edward's Hospital Fund, and of £2,200 from the National Relief Fund, Guy's is faced with a deficit of over £22,000 for the year 1920.

This year we shall have the additional expense of the new Massage Building, the new Children's Ward (the conversion of the portico in the Park into the Children's Ward was estimated to cost £2,000), and for the proposed new Clinical and Obstetric Wards which are to be built on the top of Hunt's House.

The Governors considered various methods of obtaining adequate funds for the Hospital, and were unanimous in deciding that the voluntary system was worth saving. They are also decided that a compulsory monetary charge made to all patients is not in accordance with the spirit of Thomas Guy's great Charity, but they appeal to all patients who pass through the Hospital to give voluntarily according to their means. It seems that, so far, about one patient in three responds to this appeal, while many of the others write regretting their inability to contribute owing to sickness and unemployment.

It has been suggested that a certain number of beds might be set aside in the Hospital as paying beds for the middle class patient. This would, however, not bring much additional income to the Hospital, and it would cause great distress among those who cannot afford to pay for medical treatment.

THE Directory of Guy's Men, 1921/22, is being prepared, and it will considerably help and facilitate the publication if practitioners will kindly at once notify the Manager of the GAZETTE of any recent qualifications or changes of address for insertion.

IT is our sad duty to publish in this GAZETTE the obituary notices of three well-known Guy's men—Sir George Savage, Mr. Reynolds Ray and Dr. C. J. Morton. All three, as these short biographical notices testify, were well known and well loved here at Guy's. We offer to their bereaved relatives our sincere condolences on their great loss.

WE regret that in publishing last week what was merely the provisional date of the Prize Distribution we misled many of our readers. This date proved unsuitable to our Treasurer, Viscount Goschen, who was to distribute the prizes. In consequence, long after we had gone to press, it was decided to postpone the distribution until Monday, 18th July. A full report of the proceedings will appear in the next GAZETTE.

THERE seems to be no limit to the things which some men will lose. A letter comes to us from the Medical School asking us to announce that a Guy's blazer has been found there, and, so far, has not been claimed. If the absent-minded owner remembers having lost such a blazer, and if he can give some brief description of his property, it will be returned to him on application at the Medical School Office.

Notice.

At a Special Meeting of the General Court of Governors, held on July 15th, HIS ROYAL HIGHNESS THE DUKE OF YORK was elected a Governor of the Corporation.

The War Memorial and the Garden Party.

FOR weeks the Hospital and all its friends had been impatiently awaiting the unveiling of the War Memorial. Everyone was mildly excited about the coming ceremony. In the College the eternal question was what should one wear. In the Home, deportment was assiduously studied. The Park with its several red and white awnings wore an air of unwonted gaiety. Everywhere about the Hospital workmen were busy putting on finishing touches against the great day. The painters had been busy with their brightest colours. The paths were rolled, the seats repaired; even in places grass had been persuaded to grow.

Then through all this bustling there slowly spread a great feeling of disappointment as it became known that the Prince of Wales would not be able to be present. It seemed almost as if the whole ceremony would be robbed of its interest by the absence of our President. We asked one another who would be able to take his place. Soon the rumour spread that the Duke of York might deputize for his brother, and when this news became confirmed by a notice from the Superintendent, harmony was re-established and the work of preparation went forward with an added zest.

On the Friday all work was at a standstill. Only in the Surgery and in the Take-in Wards was there any sign of active hospital work. Everywhere else patients were being invested in the reddest of red blankets and were being (wherever possible) escorted to vantage points from which they might catch a glimpse of the proceedings. In the Children's Ward the nurses were putting an extra polish on the faces of the excited youngsters, whilst in the Colonnade tables were being loaded with cups and cakes.

Towards two o'clock the first of our guests began to arrive, and the stands near the Memorial steadily began to fill. Outside, in Maze Pond, the Borough had already begun to assemble, and grubby clamouring little kiddies crowded round the gates, making sure of their positions for the ceremony. Soon the stands were full, the special constables (who wore blue and gold rosettes as their badge of office) found their work of keeping back the people from the vicinity of the Memorial becoming hotter and more and more arduous. Long before the Duke arrived all the seats had been taken, and every

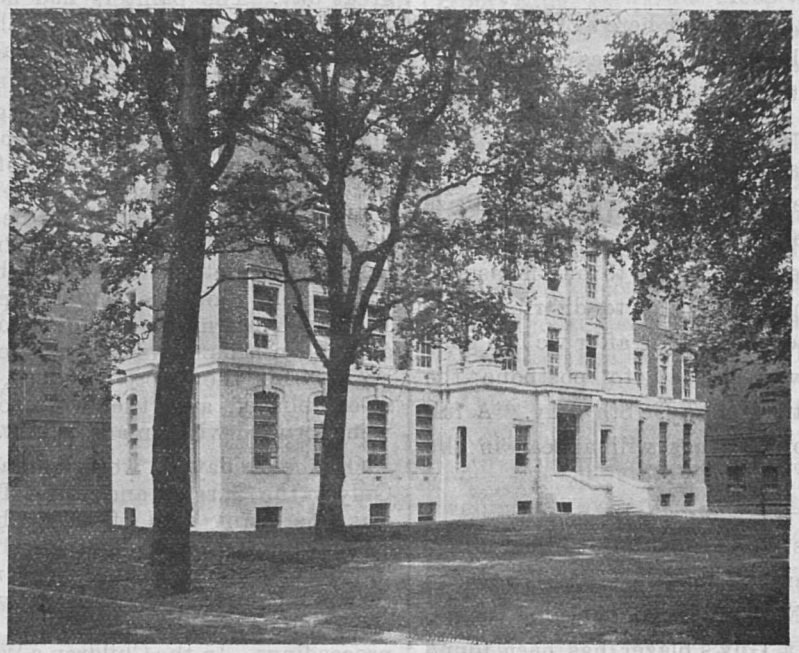
window and balcony which commanded a view of the arch was crowded.

The Colonade was lined on the one side by a row of patients in their wheeled chairs and by a body of ex-service men who are in the employ of the hospital, whilst opposite was a long line of nurses. Down through this guard of honour came the procession of Members of the Hospital Staff led by the Senior Physician and Surgeon.

The gay colours of their academic gowns and hoods lent an air of pageantry to the proceedings. When they had taken their places on the left of the Memorial another procession made its way amid cheering down the Colonnade and out to the Memorial. The Duke of York with Viscount Goschen was followed by Mr. Cosmo Bonsor, the Matron, the Superintendent and the President of the Residents.

When the Duke of York had taken his seat on the dais before the Memorial, Mr. Cosmo Bonsor read an address to the Duke setting forth an account of the meaning and the objects of the Memorial Fund. His address was followed by speeches by Dr. Fawcett and Sir Alfred Fripp. Then the Duke of York unveiled the Memorial, and after having spoken from the dais proceeded to the new Massage Building which he declared open. Viscount Goschen in speaking at the opening of this building announced that at a Special Meeting of the Governors the Duke of York had been elected a Governor of the Hospital. This news was received with great enthusiasm by all who were near enough to hear what was being said. For throughout the afternoon there was such a continuous clamouring from the children assembled in Great Maze Pond that only those in the vicinity of the speakers were able clearly to distinguish what was being said.

After H.R.H. had left, the crowd of spectators that had been massed together round the Memorial surged out and filled the Park, the Home, the School and the Wards. Everywhere the sights of the Hospital were being pointed out. Perhaps the most visited spot was the Children's Ward, where the babies soon became thoroughly frightened and excited, so that for the chief part of the afternoon the Park was filled with their howling. It was strange to find that though such spots as the Gordon Museum (which can have very little attraction to the layman unless he be morbidly inclined) always had their quota of sightseers, yet such interesting parts of the Hospital as



THE NEW MASSAGE BUILDING.

the Chapel and Court Room were relatively little visited.

So pausing here and there for tea, one wandered uncomfortably in the sweltering heat and the uncomfortable dress which convention demanded, from the College to the Home, from the Park to Colonnade, and back again, realising at last the glories and the responsibilites of the Hospital Garden Party. Then everything was over, the orchestra had played their last tune, the last guest had gone, the last cup of tea had been drunk, and we went back to the College thankful that so pleasant a function of pre-war days had been revived, yet tired, and still more thankful that it was all over.

Guy's Hospital.

UNVEILING OF WAR MEMORIAL, Friday, July 15th, 1921.

SPEECH BY MR. H. COSMO O. BONSOR.

As Chairman of Guy's Hospital War Memorial Committee I have been instructed to open our proceedings.

We regret the cause that prevents His Royal Highness our President being with us to-day, and we express the hope that rest and care will soon restore his health and energy. We welcome your Royal Highness as a Governor of our Corporation, and are very grateful to you for coming at so short a notice to unveil the Memorial which has been erected by the friends of those belonging to Guy's Hospital and Medical School who lost their lives in the Great War.

Our Hospital and our Medical School are open to the whole world; we have no religious test. A large number of our students come from His Majesty's subjects in India and the Dominions; we had to be careful in our endeavours to please, not to give offence, and we could have no religious dedication.

Our Committee consulted our subscribers as to how their donations of upwards of £5,000 should be spent.

They decided that three-fifths of the amount should be vested in trustees, to provide assistance, if necessary, to the dependents of Guy's men who had fallen in the War, and to form a permanent War Memorial Scholarship for the relations of those who had lost their lives or been disabled in the War, who should have preferential claims in the examination to obtain it.

That the balance should be applied in erecting a Memorial in the Hospital Grounds.

Our Committee have handed to Trustees £2,000 for the purposes of the Scholarship, and the first Student has been elected.

When it came to the choice of a fitting Memorial we had many meetings. We consulted an eminent architect and inspected many designs: we were in a difficulty, and it was our Hospital Architect, Mr. Walford, who suggested that an arch should be erected through which, all our Students both now and hereafter would pass.

Mr. Walford's proposal met with unanimous approval.

We are here to-day to express our gratitude to all those who came forward to join His Majesty's forces at the great crisis in the History of our Country: we appreciate their unselfishness and devotion in breaking off their medical studies, interrupting and probably damaging their future prospects for our safety and for their King and Country's Cause.

We tender to them our heartfelt thanks.

We are here also to honour and remember those who gave their lives for us.

Your Royal Highness, it is impossible for us who stayed at home, to put our feelings into words.

We have erected this archway with their names attached in order that their memory shall always be with us reminding us of their devotion and sacrifice and inspiring us to follow their example of putting their Country's good before personal ambitions.

SPEECH BY DR. FAWCETT.

In consequence of holding the position of Senior Physician I am accorded the privilege of adding a few words to those offered to you, Sir, by Mr. Cosmo Bonsor.

Not only is there this Memorial Arch, under which Students and Staff will pass in their frequent "comings and goings" from Hospital to College, but also from our funds we have been enabled to allocate three other sums of money in accordance with the wishes of the majority of the subscribers, viz:—

(2) £1,000 for the assistance, if necessary, of the dependants of Guy's men who fell in the war.

(3) £2,000 for the endowment of Scholarships, with preference to the sons of Guy's men.

(4) £300 for a "memorial" adornment of the College Dining Hall.

You, Sir, will, I am sure, approve of our distribution of the funds, and in unveiling this memorial to-day, you add yet one more favour te those already conferred by your Royal House, His Royal Highness The Prince of Wales, our President, and your beloved Father and Grandfather, upon this great foundation, of which its sons are so proud.

All over this Empire of ours, Guy's men, their parents and sons, will thank you for the kindly thought and gracious act by which you to-day record in public your sympathy with us at Guy's in the loss of the men whose names are engraved on these columns, and who, giving up their lives "for King and Country," have exemplified in full the meaning of our motto of "Dare quam accipere." May we, who pass under this arch in future, never forget what we owe to them, and play our small part in life the better for the way they played theirs.

On behalf of the Staff and the Students may I ask you, Sir, to express to His Royal Highness the Prince of Wales our great regret at the cause which prevents him being present to-day, and our sincere wish that he may speedily be restored to that measure of health, vigour, and the power to enjoy life which we invariably associate with him, and by means of which he has already done such incalculable good in maintaining and promoting the spirit of peace and goodwill among men, without which our land cannot prosper.

SPEECH BY SIR ALFRED FRIPP.

Your Royal Highness, My Lord, Ladies and Gentlemen,—It is characteristic of the kindness and consideration to which all of us who serve under the Governors bave become accustomed, that their spokesman should wish on this memorable occasion to be associated with representatives of the Schools which are so intimately connected with the work of the Hospital.

The Senior Physician and the Senior Surgeon have therefore the honour to offer to you, Sir, the thanks of all our colleagues for your kindness in coming to-day.

Professor Pembrey is really the man upon whom fell the brunt of the work of carrying through this Memorial. As Acting-Dean during the War he took up the Secretaryship of the Memorial Committee, and has discharged the difficult and delicate duties with great tact and ability. We are very grateful to him and congratulate him upon the success attained.

Well, Sir, this solemn occasion is also a very proud one, and indeed represents one of the milestones in the successful development of the foundation of Thomas Guy. As we have already been reminded it is exactly 25 years since that other occurrence—epoch making in the history of Guy's—when His late Majesty, King Edward, came to the rescue of our Hospital, and becoming our first Royal President, initiated a policy of reconstruction and re-endowment which has been completed under the Presidencies of his Son, King George, and his Grandson, the Prince of Wales.

Under these three successive Royal Presidents the Governors of the Hospital, represented with rare tact, judgment, and enterprise by Mr. Cosmo Bonsor, who at the same time—25 years ago—took up the Treasurership, and by Viscount Goschen, who followed him, and served whole-heartedly by that great master and pioneer in Hospital administration, Sir Cooper Perry, have succeeded in maintaining the Hospital and Schools in the fore-front of medical, surgical, and dental education and practice.

This quarter of a century has been an eventful period, not only in the history of the world, but also in the amazing rapidity of development of our profession and the sciences upon which it is founded. Great and rapid as have been the changes that have marked this dramatic era, they are nowhere greater than in the field of our own profession, and we are thankful that our Governors have proved themselves to be of the kind that they know the importance of changing with the times. It is to their prevision and understanding that we owe the healthiness and the happiness to-day of all the large family whose destinies are in their hands, and also the fact that when the war broke out Guy's was found ready to act its proper part.

We who have lived through are proud of the part played by the sons and daughters of Guy's. You, Sir, are about to unveil the list of those who made the great sacrifice in the War, and while we all to-day mourn with their relatives, we believe that the honour and love they felt

for their Alma Mater was no less than the honour and love they felt for their country.

These names—upwards of a hundred—represent the flower of the generations of students which matured during the eventful quarter of a century to which I have alluded. The intimacy, the confidence, and the mutual consideration and forbearance which have marked the relationship of the various estates of our family, have resulted in that high degree of happiness and *esprit de corps*, which is at once our most treasured possession and our strongest bond. Perhaps the world-wide kinship of Guy's is knit all the closer by the loss of those whom to-day we are assembled in our old home to honour—for families are wont to be knit closer by grievous loss.

We are proud of our memories of them as well as of the other splendid achievements of Guy's men since our foundation two centuries ago. We are happy both in the work and in the sports of our healthy, vigorous, and successful present, and happy in the confidence that our future will be no less successful under Governors no less enlightened, and happy also in the knowledge that whenever occasion demands we shall be helped and encouraged by one of the members of your Royal House, who have so often honoured us as you, Sir, have to-day, when you so kindly came among us, and took up your membership of the Guy's family, and filled the place left vacant by the much-regretted indisposition of our President, the Prince of Wales.

Guy's Hospital War Memorial Fund.

THE widespread desire, amongst all connected with Guy's Hospital that a permanent Memorial should be established to commemorate the services of Guy's men in the war was recognised at the School Meeting of November, 1917, when an Appeal Committee was appointed. The first meetings of this Committee, under the chairmanship of Mr. Cosmo Bonsor, the President of the Hospital, were concerned with the scope of the appeal and the constitution of the War Memorial Committee. The proposals which received most consideration were the following:—

(a) A Memorial recording the names of Guy's Medical and Dental men who have fallen in the War to be placed within the precincts of the Hospital.

(b) A Fund to enable the sons of Guy's men, who have fallen, or suffered by the War, to receive free or assisted education at Guy's Hospital Medical or Dental Schools.

(c) A Fund to enable the daughters or widows of Guy's men, who have fallen, or suffered by the War, to receive free or assisted education as Nurses or Pupils in the Special Departments (such as the Massage and Light Departments) of the Hospital which are open to Women.

(d) An Endowment Fund for Entrance Scholarships to be open, in the first place, to the sons of old Guy's men.

The War Memorial Committee was constituted as follows:—

A.—GOVERNORS' REPRESENTATIVES.

President of the Hospital (H. Cosmo O. Bonsor, Esq.), Treasurer of the Hospital (The Rt. Hon. Viscount Goschen), Chairman of the House Committee (F. P. Whitbread, Esq.), Sir W. Cameron Gull, Bart., Colonal F. A. Lucas, R. E. Johnston, Esq., A. C. Cole, Esq., J. Robarts, Esq., H. A. Trotter, Esq., Major Oswald Magniac.

B.—REPRESENTATIVES OF THE HOSPITAL AND SCHOOL STAFF.

Dr. Hale White, Mr. Golding-Bird, Mr. Symonds, Sir Arbuthnot Lane, Mr. Higgens, Mr. Maggs, The Senior Physician (Dr. Shaw), The Senior Surgeon (Sir Alfred Fripp), Mr. Hopson, Mr. Steward, Mr. Rowlands, Dr. Cameron, Mr. Bromley, Dr. Eyre, Dr. Laidlaw, Mr. Ryffel, The Hon. Dean (Sir Cooper Perry), The Sub-Dean (Dr. Pembrey).

C.—REPRESENTATIVE GUY'S MEN (PAST AND PRESENT).

Mr. E. D. Bascombe, Mr. W. A. Bulleid, Mr. L. S. Debenham, Dr. Wheelton Hind, Dr. E. R. Mansell, Dr. R. C. Mullins, Sir Shirley Murphy, Dr. C. D. Muspratt, Dr. C. J. Pinching, Mr. A. E. D. Pridgeaux, Dr. R. J. Ryle, Sir George Savage, Dr. H. J. Spon, Mr. Chas. Spurrell, Mr. W. E. Wood. *Ex-officio.*—The President of the Residents, The Editor of GUY'S HOSPITAL GAZETTE.

The Joint Treasurers appointed were Mr. Cosmo Bonsor, Mr. Maggs, Dr. Shaw, and Sir Alfred Fripp; and Dr. Pembrey was made Honorary Secretary.

An appeal asking for subscriptions, suggestions, and expressions of opinions on the four proposals was issued in November, 1918. The question of the issue of a Special War Memorial Number of GUY'S HOSPITAL GAZETTE was referred to the Editor of the GAZETTE, assisted by a Sub-Committee, composed of Dr. Shaw, Sir Alfred Fripp, Mr. Hopson, and the Honorary Secretary. The result was the publication of the War Memorial Double Number of the GAZETTE on December 28th, 1918.

At the meeting of the Committee on June 12th, 1919, it was announced that about 390 subscriptions had been received, but only 183 subscribers had returned the voting papers relating to the the proposals (a), (b), (c), and (d) given above. It was thought well, in view of some objections to these proposals to issue a further appeal, in which the following additional suggestions were made:—

1. A portion of the fund to be devoted to the new "Clinical" Ward shortly to be built, which should be called the "War Memorial Clinical Ward," and have inscribed upon its walls the names of the Guy's men who have lost their lives owing to the war.

2. The adornment of the Dining Hall of the College, including memorial panels bearing the names of the Guy's men who have lost their lives in the war.

3. A portion of the fund to be allocated to form the nucleus for endowment of a Dental Research Scholarship.

At the same meeting it was decided that the Fund should be closed on September 30th, 1919, and a general meeting of subscribers called in October, 1919, to decide upon the form or forms which the Memorial should take.

The Committee held its final meeting on October 28th, 1919, when, after considering a statement of accounts and the results of the analysis of the preferences for the proposals set forth in the first and second appeals, it decided to place before the General Meeting of the subscribers the following recommendations:—

(i.) To allocate the sum of £5,300 as follows:—

(a) £2,000 for the erection of a permanent memorial in the "Park."

(b) £1,000 for the assistance, if necessary, of the dependents of Guy's men, fallen in the war.

(c) £2,000 for the endowment of Scholarships, preferably for the sons of old Guy's men.

(d) £300 for the memorial adornment to the College Dining Hall.

(ii.) To appoint an Executive Committee to carry out the scheme.

The General Meeting of Subscribers held on the same day approved these recommendations and appointed the Executive Committee, constituted as follows:—Mr. Cosmo Bonsor, Sir William Hale-White, Mr. Maggs, Dr. Fawcett, Sir Alfred Fripp, Mr. Spurrell, The Dean, the President of the Residents, the Editor of GUY'S HOSPITAL GAZETTE, and Dr. Pembrey (Honorary Secretary). Later on Mr. Eason and Mr. Walford were co-opted.

The Executive Committee held several meetings to consider the type of the Memorial and finally selected the plans of the Memorial Arch designed by Mr. Walford. There was much difficulty in making a list of the names to be inscribed upon the Arch, for there was no exact guide for the selection of the names; every case was considered as far as possible on its merits, and room was left for the inscription of new names, if it should be necessary.

At the request of the Committee and the School, the Governors of the Hospital accepted in trust the sum of £3,000, and allocated to the Guy's War Memorial Trust Fund £3,519 1s. 3d. 5 per cent. War Stock 1929/47. In this way provision has been made for the assistance, if necessary, of the dependents of Guy's men, fallen in the war, and the endowment of Scholarships, preferably for the sons of old Guy's men.

The School accepted the suggestions of the Executive Committee that of the two War Memorial Scholarships tenable at Guy's one should be for Medical and one for Dental students, and further agree that a War Memorial Scholarship for Senior Medical Students should be included, the School to bear the charge as a contribution to the War Memorial Fund.

The Memorial Decoration of the Dining Hall of the College has been postponed pending possible extensions of the Club.

The subscriptions to the Fund have been acknowledged from time to time in the GAZETTE, and this will be done in future, for it was arranged at the time of the first appeal that subscriptions should be spread over a period of five years. It is proposed to publish the audits of the accounts in the same way.

Obituary.

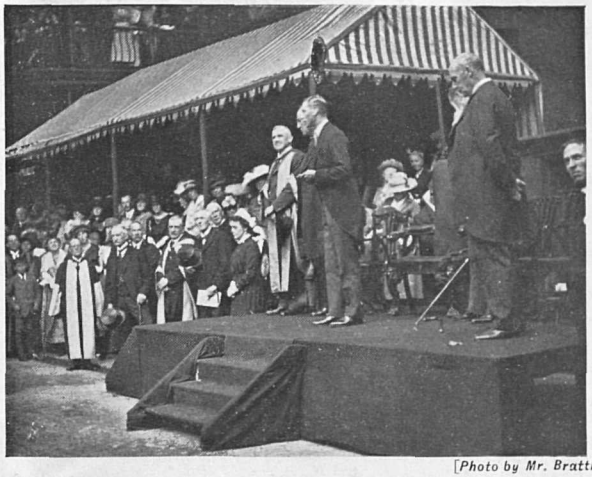
E. REYNOLDS RAY.

WHEN a coach and four took people from Dulwich to the City, and schoolboys to Merchant Taylors' School in the early fifties, Ray was a daily passenger. His father, educated under Bright, Addison, Hilton and other great men, held the leading position as a General Practioner in Dulwich, and took a prominent lead in social life. He died of a then little known disease-Ulcerative Indocarditis. Addison saw him frequently and published an account of the case in the Lancet. Reynolds Ray entered Guy's in 1859 and was one of the leading men of his time and had he not been obliged to help his father who had begun to fail, he might have obtained a position on the Opthalmic Staff.

As House-Surgeon he must have been a popular resident, for to him was awarded the

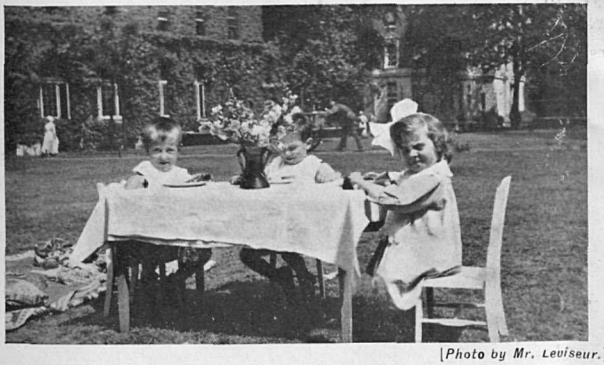
[Photo by Mr. Walker.]

MR. EVANS AND MR. FOX.



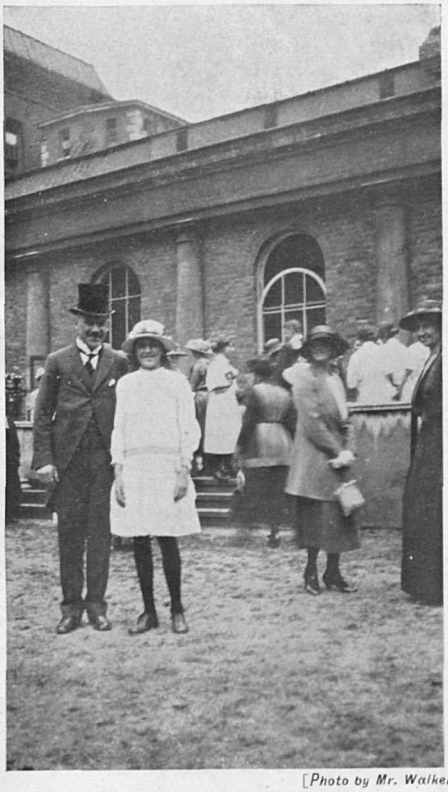
[Photo by Mr. Brattle.]

THE DUKE OF YORK SPEAKING AT UNVEILING CEREMONY.



[Photo by Mr. Leviseur.]

THE BABIES: ONE OF THE CHIEF ATTRACTIONS AT THE GARDEN PARTY.



[Photo by Mr. Walker.]

DR. FAWCETT.

distinction of having his photograph presented and hung in the dressers' room, where I well remember seeing it as a Student, along with two others, Thurston of Ashford and Higgins. In Dulwich he became like his father the leading practitioner.

He was joined by another notable Guy's man, John Rand, and when he retired, by one still living, though, alas, in poor health—Harry Blatherwick, who maintained, like his predecessors, the highest traditions of the family physician.

Moving to town, he continued to practise up to six months before his death, though for some months he knew he had a mortal illness. He was well enough to dine with the writer on Christmas Day last, and walked back to his chambers, and no one could have detected any sign of illness, or loss of gaiety. This fortitude he maintained until the advancing of the malady undermined his resistance, and then he would apologise for "giving way," and for the trouble he was causing. This was of a piece with his fine disposition, and endeared him the more to others.

Ray was a sportsman in every fibre of his being. As a boy his love for horses was widened in his daily coach drive from Dulwich. He drove beautiful horses in his practice and handled the ribbons as only a master can. When nearing his 80th year, he took a boy for a drive on a four-in-hand, and at the request of the coachman took the ribbons for a ten mile stage, involving a gallop through a swollen stream. It was a fine performance, and thoroughly enjoyed.

To the last he was a frequentor of Lord's, of which he was for many years a member, and at the Bath Club Ray kept in touch with all kinds of sport. He was an expert fisherman and a good shot.

In his earlier years he was well known as a breeder of English bloodhounds, winning prizes with dogs that became famous, and for fifty years he was a member of the Kennel Club.

As a student he did his share of boxing in the little quadrangle outside the old dissecting room, knocking out the bully of the day. Observing the punishment he was receiving some of his friends begged him to give in, but that Ray would never do once he had undertaken anything, and he held on, getting in the last blow, and taking the shine out of the bruiser to the delight of everyone. Moxon has told me of these bouts with the gloves in which he also participated. Ray rowed with Pye-Smith and others in the Guy's boat in 1863.

When the call for special constables was made during the war Ray at once joined the force, together with his old friend Higgins in whose house he dwelt.

With him also he joined the staff of the Horton Military Hospital at Epsom, and there he did yeoman service, and gained the esteem and affection of not only the patients but the nursing staff, as witness the birthday gifts from all branches. For months and especially all through the influenza epidemic, he worked continuously, reaching Epsom soon after nine every morning and often not leaving till 3 o'clock.

In addition to this he went on duty as a "Special" from 2 to 6 a.m. on three nights in the week, no mean undertaking for a man at 77. Mr. Higgins in addition to his work at Horton, also acted as a night special. They were a fine trio these three at Horton, Higgins over 75 doing high class plastic surgery of the eylids and face, Ray over 76 as Physician attending daily in the wards, and Cooper Wilkinson well over 60, giving anæsthetics. Later, Ray was in command of his section of the "Specials" and had charge of the ambulance. At the review, he, with the Commandant and one other led the march past of their contingent. Sixty years before, Ray had paraded before his Sovereign in the first review of the newly raised volunteer forces.

His devotion and loyalty to Guy's was ever a marked characteristic, and Teddy Ray was a familiar figure at all gatherings of old students. He read the GAZETTE and was a subscriber to the Guy's Quarterly. He was a lovable man, and had many friends amongst his old patients who remembered him in many affectionate ways during his long and painful illness.

The passing of such men not only removes a link with the past—for he was a pupil of Addison and Bright and Hilton—but deprives us of a personality retaining, but for the accident of his malady, a vigour, a grace of manner, and a generosity surely rare at four score years. Looking at Ray a year ago, with his dark hair, his bright blue eye, his activity, and his unwrinkled face, you would have set him down as a well-preserved man of fifty or sixty.

C. J. S.

SIR GEORGE SAVAGE.

By the death of Sir George Savage Guy's has lost one of its most distinguished physicians. Entering the Hospital over sixty years ago, he quickly showed himself to be a man of untiring energy, and one who had taken up the calling of medicine for the love of the work. He was a Treasurer's Gold Medallist and held several House appointments. Later he was appointed to one of the House appointments, or clinical assistantships as they were called at that time, at Bethlem Royal Hospital. It was during this period that he became attracted to the study of mental disorder, and he decided to devote his life to this branch of medicine when he was given the post of assistant Medical Officer to this Hospital in 1872. Seven years later he was appointed Resident Physician at Bethlem, a post he held for ten years. He soon became recognised as an authority and teacher upon mind disorder, and in 1896 was appointed Physician for and Lecturer in Mental Diseases at Guy's. He was one of the most fascinating and brilliant of lecturers, and in consequence his classes and demonstrations were highly popular, and those for post-graduates were attended by men from the British Dominions and the United States in increasing numbers. Savage was fearless and was not a man to be bound by conventions, and it was perhaps this largeness of mind which constituted one of the most attractive sides to his character. In 1889 he retired from Bethlem Hospital, and from that time onwards until his death he devoted most of his time to consulting practice. His opinion was frequently sought by the Home Office, and he became a well-known expert on mental diseases at the Law Courts.

Savage held many high offices in various learned societies. He was President of the Section of Psychology at the annual meeting of the British Medical Association in Belfast in 1884, and in 1886 he was elected President of the Medico-Psychological Association of Great Britain and Ireland, and for many years he was co-editor of this Association's "Journal of Mental Science." His presidential addresses showed great human understanding, and anyone who reads them will appreciate why he became so successful a physician. In 1912 he was elected to be the first President of the Section of Psychiatry of the Royal Society of Medicine. He was Lumleian Lecturer at the Royal College of Physicians of London in 1907, and two years later he was Harveian Orator and took for his subject "Experimental Psychology and Hypnotism." He was examiner in Mental Pathology at the University of London. Throughout his life he was a voluminous writer, and his papers are to be found in many English and American Medical Journals. His text-book on "Insanity and Allied Neuroses" ran into many editions. In 1912 the Order of Knighthood was conferred upon him, a recognition which had for some time been expected by those who knew his work.

Savage developed the social side of life in no small degree; he had a great number of friends and at one time it was said that there was never a medical dinner at which he was not present. He was a man of wide interests and possessed no mean knowledge of plants and was a great lover of gardens. Mountaineering and fishing were his favourite recreations and in 1878 he became a member of the Alpine Club and subsequently he became Vice-President of this Club, a position which he held for three years. Sir George Savage was twice married and he had one son and one daughter. He preferred to remain at work rather than to retire and throughout the war he gave much of his time to treating cases in the Special Hospitals for Officers. During the last years it became obvious to his friends hat his strength was slowly but steadily failing, but he never gave in and up to the last he could be seen in his accustomed place at Guy's, as that of a great physician, a delightful and interesting personality and one who always took a keen interest in the student and his work.

Dr. C. J. MORTON.

We regret to announce the death, on May 28th at Territet, at the age of 57 years, of Dr. Charles James Morton, who was appointed Radiographer to Guys in 1907 and resigned in 1912, owing to the onset of the disease which subsequently proved fatal.

Dr. Morton received his professional education at Edinburgh, where he took the degree of M.B., C.M. and the diploma of L.R.C.P., L.R.C.S. Ed., and L.R.F.P.S. Glas. in 1886. After studying in London and Vienna he took the M.D. degree in 1890, and began private practice at Walthamstow. While there he was Secretary of the East London and Essex District of the Metropolitan Counties Branch in 1900—1, Secretary to the Walthamstow Division in 1903—5, and Representative of the Wathamstow Division on the Representative Body for 1904—7. Before his appointment to Guy's Hospital

he studied Radiography with the late Dr. Ironside Bruce and elsewhere. As a Radiographer he was a member of the Council of the Section of Radiology and Electro-therapeutics of the Royal Society of Medicine, and was one of the foremost Radiographers of his time, and contributed several articles on his subject to medical periodicals.

In 1914 Dr. Morton received a commission in the R.A.M.C. and was appointed Radiographer to the Pavilion (Indian) Hospital, Brighton, and the 2nd Eastern Hospital. He served till March, 1920, and later in the year his health began to fail again.

Dr. Morton was of a retiring disposition, but was much loved by all who were fortunate enough to know him intimately. He leaves a widow and daughter.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

The "Rag" at the Rugby Final.

DEAR SIR,—I was much interested to read in my last copy of the GAZETTE of April 2nd, that Bart.'s again took no part in the "Rag" at the Rugby Final in March.

Such Rags as still take place appear to be no less vulgar exhibitions than they were before the War, and can surely only provide amusement for the Raggers themselves.

May I suggest, then, that we follow the excellent example of our colleagues at Bart.'s, and, by giving up such irreverent vulgarity, try to raise the status of the junior medical student in the opinion of the "Man in the Street."—I remain, Sir, yours faithfully,

ERIC STUART TAYLOR.

Hong Kong, China.
17th May, 1921.

Suggested Improvements to the "Gazette."

DEAR SIR,—Your correspondent, Mr. C. Thompson' suggests that the Clinical Lectures shall be so printed that they may, without extraneous material, be cut out and kept. I did suggest the same five or six years ago, but a socialistic editor was then in charge, and as usual with such—I mean extreme socialist—I neither received acknowledgment in or out of the GAZETTE. It is more than amusing, the suggestion that because London does it therefore Guy's should. It reminds one of the fishmonger who suggests your having a cut of that salmon as Lord So-and-So has just had some. What the d—— has Lord So-and-So to do with me? He might be a fool —probably is. The point is, is the salmon good? Common sense is all that is necessary to decide whether the GAZETTE considers its Clinicals worth so printing, and as the GAZETTE is probably well supported by Guy's men in practice, I think their opinion is worthy of consideration.

The opening of the GAZETTE to general practitioners' experiences is well. May I suggest a few points to a Guy's man. Never mind degrees or prizes, or aught such; get every bit of clinical knowledge you can; keep records of cases you see; use tact in all your work, and you will secure better results in practice particularly so. Let your examination of your patient be made with care respecting the modesty of the patient. Be firm in your treatment and obtain respect. Above all, keep notes. Diagnose each case; never mind the mistakes and prognose when you can, and remember not to rush into your patient's bedroom as if it were a ward of a general hospital; if you do, you will soon find you are not wanted. Cultivate ease of manner with quiet decision, and always be straight with your patient. As an orientalism has it: "A man, an arrow, and an answer should all be straight."—Yours,

F. B. JUDGE BALDWIN.
One time an H.P. at Guy's.
"Cawdor," Cheltenham.

Lectures on General Practice.

DEAR SIR,—If it does not look too pompously patronizing will you permit me to congratulate the Hospital authorities, and yourself, on the "G.P." lectures.

I think it marks an epoch, and an important epoch in the profession; it is a graceful recognition of general practitioners by Harley Street, which will be much appreciated, and will be beneficial to ourselves and to our patients, and (passing bold) may I say to Harley Street!! I think the choice of lecturers was singularly happy, and Dr. Seymour Price and Dr. H. M. Stewart have fulfilled a by-no-means easy task with great ability.

I could with senile volubility expand many of the issues raised, with great pleasure to myself, but of little benefit to your readers.

One point though—the Wonder Year of Travel recommended by Dr. Price. Most essentially "yes!" and more so. I would advise the Navy or the Army for the shortest period that carries a gratuity. With luck it may open but a career, if not you resign with quite a comfortable little sum to help you to really start practice, and a very interesting mental rumination of men and things for the rest of your life.—I am, Sir, etc.

GERALD SICHEL.

Sevenoaks.
July 14th, 1921.

The late Dr. A. Taylor.

DEAR SIR,—Dr. Allport's letter referred only to the late Dr. Taylor's prowess in the football field. May I be permitted to say a few words about him from another point of view?

It is seldom that one meets a more perfect specimen of manhood than Arthur Taylor. Not only had he the physical attractions of a splendid figure and a handsome face, with manners and a bearing to match, but mentally he was equally well equipped. Possessed of a keen intellect, he exhibited a shrewdness and clearheadedness in dealing with professional problems which were far above the average He had a justifiable confidence in his own powers, but he never exhibited a trace of "side." One could not imagine Taylor losing his head in any emergency. He did not know the meaning of fear, and in all his actions was straightness itself.

He has always been my ideal practitioner. Endorsed with every quality conducive to success, I could see nothing lacking in him. Generous and most thoughtful for others, he never dreamt of sparing himself. A sportsman in the truest sense of the word, Arthur Taylor was an English gentleman of the best type whom we all loved and of whom we were all proud. Guy's never had a worthier son.

These few disjointed sentences, I fear, do scant justice to his memory, but at least they come straight from the heart.—Yours, etc., H. C.

Metropolitan Asylums Board,
Embankment, E.C. 4.
19th July, 1921.

DEAR SIR,—The enclosed note was sent to the Surgery by the hand of a small boy. Had his mother diagnosed the existence of acidosis?:—

"Please Doctor My little boy is out of salts and a breaking out since last week will you kindly give him some medicine Please."

Honours.

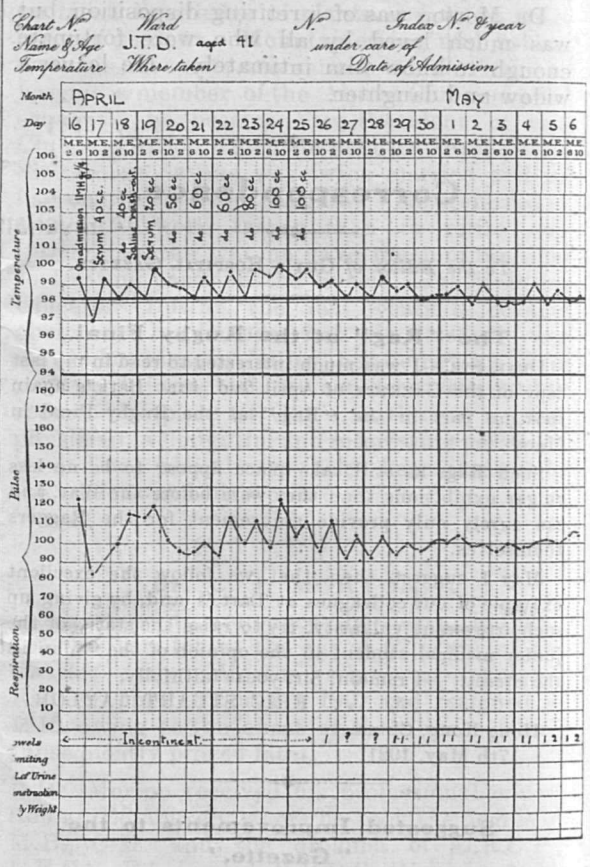
H.R.H. King Husein of the Hedjaz has been graciously pleased to confer the order of the Nahda (3rd class) on Major R. G. Gayer-Anderson (late R.A.M.C.), of the Ministry of the Interior, Cairo, for services rendered by him as political officer in Arabia during the war.

THE EDITOR will, at all times, be glad to consider articles or sketches, provided that they are accompanied by the writer's name and address, not necessarily for publication. The payment that the GAZETTE *can offer is merely nominal. Authors who desire reprints of their papers should make their own arrangements with the printers when they return their proofs. All contributions to be addressed to the Editor, "Guy's Hospital Gazette," Guy's Hospital, London, S.E.*

Case of Ulcerative Colitis Treated with Serum.

THE following case may be of interest to general practitioners in view of Dr. Hurst's article in *Guy's Hospital Reports*, Vol. 71, No. 1, and other recent publications suggesting the dysentery bacilli or the amœba histolytica as the responsible organisms for ulcerative colitis in this country.

J.T.D., aged 41, a workman on the railway, who had never been out of England, sent for me on February 25th, 1921, suffering from colitis.



History.—A year previously patient had been treated in Oakham Cottage Hospital for the same complaint, from March 23rd till June 1st. He had been considered dangerously ill much of the time. Treatment had consisted of strict diet, salts, bismuth, salol, charcoal, etc. His stools had been cultivated and grown streptococcus longus amid many other of the common intestinal flora. He had made a slow recovery after a time and remained well until a few days before I saw him.

Condition when first seen.—Stout, pale and weak. He was passing about 10 to 15 motions a day, with blood and mucus. The stool was not much like the "red-currant jelly" stool, we used to see in bacillary dysentery, but chiefly consisted of blood-stained fluid and shreds of mucous membrane. He had a lot of pain and tenesmus.

Course of disease and treatment.—Patient was put at once on a fluid diet and sodium sulphate given three times a day. Pain and tenesmus were relieved. Daily hypodermics of emetine 1 gr. were then given for six days, but seemed to do no good in the way of reducing either number of stools or amount of blood. They were discontinued. After about a month of the sulphate treatment with no improvement, salol and bismuth and salol were tried in turn. Diet was varied considerably, but had no effect. After two months he was incontinent, very weak, wasted and quite determined to die. I then persuaded him to come into hospital and gave him serum. The chart, I think, shows sufficiently well his subsequent progress. Admitted April 16th, he was discharged convalescent in less than four weeks. The serum used was from the Lister Institute, but was injected subcutaneously and not intra-venously. Patient was incontinent for about a week and so motions could not be counted. Improvement in general condition and reduction in the amount of blood passed was noticed about the third day. A few argyrol irrigations (1 per cent.) were given during the first week, but were not well stood by the patient. A few bad teeth were dealt with while in hospital.

B. E. JERWOOD.

Reviews.

Diseases of the Throat, Nose and Ear. By Dan McKenzie, M.D., F.R.C.S.E. Pages xvi. and 646, with two coloured plates and 199 Figs. in Text. (Messrs. William Heinemann (Medical Books), Ltd., London.) Price 42s. net.

This book is the antithesis of Dr. Johnson's leg of mutton, and of what Croker's edition of Boswell's Life was in the eyes of Macauley. It is well compiled, well arranged, well written and well printed. And yet we have delayed six months to review it—a delay for which the reviewer is entirely responsible, and for which he apologises to the author and publisher of the book as well as to the editor of this journal—we have delayed because each time that we have turned over in our minds the nice things we might say about the book or about Dr. Dan Mackenzie we have been faced at the end by the questions, "For whom was this book written? and what class of practitioner or student can make use of it?" and, frankly, we have been unable to find an answer. We do not think the undergraduate student will ever tackle 400 pages of a branch of medicine and surgery, the practitioner will cavil at paying two guineas for a book in a single subject, while for the post-graduate student thinking of taking up oto-laryngology as a special subject there is not sufficient detail. Reduce the price of the book by printing it on a less elaborate paper, by cutting out both the coloured prints, and by doing away with all the pictures of instruments and most of the other pictures, and add some more references whereby the student can be led to follow up the many useful thoughts throughout the volume, and we should have a book that would be of value to all three of the above classes of readers.

It is a remarkable thing that most of the books on this speciality are riddled with pictures of instruments—frequently of those designed or specially used by the author—as though the use of instruments could ever be taught in a book, and as though the correct practice of oto-laryngology depended upon the use of a special armamentarium.

Who should teach this subject and how is it of interest, in the light of the report of the Post-Graduate Medical Committee recently published? This body has stated that they do not see their "way to recommend that post-graduate instruction should be undertaken at the undergraduate schools," although they leave a loophole for it to be carried on there in such a branch as oto-laryngology by saying that "The departments of the undergraduate schools would be regarded as 'Special Hospitals' for the purpose of their system." They advise that a Central Post-Graduate Hospital be set up and that "The great special hospitals would be closely associated with the central hospital under administrative arrangements, and their post-graduate courses would be organised in connection with the programme of work at the centre." In other words it is the hospital to which Dr. Dan Mackenzie is attached that should, with one or two others, bear the brunt of post-graduate teaching in this speciality. We believe that it already does so; but as we hope to see far more systematic post-graduate study in the future, and far more post-graduate teaching done in London than has been in the past, this school may have a great future before it. We do not think that a man could better his selection than to go to the Central London Nose, Throat and Ear Hospital now. Before the war Post-Graduate Students were driven to Vienna, now they are being driven to the States. The sooner we realise that good post-graduate study can be got not only in our own city, but also in Edinburgh or the provinces, the better for us. We do not mean that excellent

chances of study are not to be found in the States. We mean that with commodities at their present rates, and with the dollar soaring in price on the exchange, many are not taking tours of study, who could well do so nearer home, others are laying up for themselves financial anxieties that they will find out-weigh the value of what they have received. We make no excuse for commenting on the high cost of this book or of the study of the subject with which it deals. The war has changed us from a wealthy nation to a poor one and we must face the fact. Money spent on education is seldom wasted; and if you have not the cash for the most expensive education, remember that the less expensive is often better.

We hope that Dr. Dan Mackenzie will see his way to reducing the price of his book, and that many will go to hear from the lips of himself and his colleagues the excellent principles which he has put forward in it.

T. B. L.

Graphic Methods in Heart Disease. By John Hay, M.D., F.R.C.P. Oxford Medical Publications. (Messrs. Henry Frowde and Hodder and Stoughton. 1921.) Second Edition. Price 12s. 6d. net.

As years go by the science of cardiology becomes more and more exact. There is still much that is obscure, but the graphic method of examination, in the hands of Lewis and Mackenzie has cast light on many dark spots and has pointed the way to further investigations, which are at present occupying the attention of numerous observers. It is almost impossible for the student or practitioner to keep abreast of all the latest developments in cardiology, but some knowledge of graphic methods is nowadays essential if the pathology of cardiac disorders is to be properly understood. It is only by the use of such methods that many conditions have been distinguished and, while much may be done in practice by quite simple investigations, the graphic method is clearly the last word. It is a permenent record. and a true one. It is only our interpretation of it that can be at fault. A sound knowledge of the principles underlying the production of these Graphic records, if not an acquaintance with the technique of their production, is the only way to avoid making errors, and even so the expert may sometimes be baffled.

Dr. Hay treats his subject in a thoroughly workmanlike way, and all his descriptions are good and clear. He is careful to avoid being dogmatic on doubtful points and is quite frank as to the limitations of the methods he describes. By no means the least valuable part of the book is the excellent collection of illustrations. These are sufficiently numerous to give the careful reader a fairly complete knowledge of the variations he is likely to meet with both in the normal and abnormal "gram"—cadiogram, sphygmogram or phillogram.

The results of Lewis's recent investigations into the nature of the various areythemias have been incorporated into the new edition, while a chapter on the electro-cardiogram has been added which, while admittedly too short to do more than touch the fringe of a big subject, is sufficiently clear to be useful and should stimulate the reader to go more deeply into a subject of absorbing interest and of ever increasing practical importance.

There is nothing abstruse about Dr. Hay's work; neither the medical ward clerk nor the rusty G.P. need fear to meet with anything beyond his powers of comprehension. It is all quite simple and eminently practical.

The Sphygmometer, Its Practical Value in Medicine. By William Russell, M.D., LL.D. (Messrs Baillière, Tindall & Cox, London, 1921.)

This work consists of a collection of lectures delivered by the writer in Edinburgh before audiences both of students and post-graduates. The author is up in arms against the unintelligent use of the sphygmomanometer. It is certainly true that most of us are taught to regard the reading of the instrument in millimeteres of mercury as an accurate measure of the intra-arterial blood pressure. Dr. Russell has long drawn attention to the fact that the resistance of the arterial wall must play an important part in producing the "pressure" reading on an instrument which works by means of an inflated arm band. He goes carefully into the conditions that after the elasticity and rigidity of the arterial value, and is much shocked by the indiscriminate use of the term atheroma to designate any pathological condition which causes the radial artery to present more or less the characters of the traditional "pipe stem" to the palpating finger. His own investigations which are here described seem to show that the commonest pathological change in a clinically arterio-sclerotic artery is an hypertrophy of the muscular tissue of the media, and not an atheroma in the strict sense of the word.

No doubt this has all been recognised by a number of those who use the blood pressure apparatus in clinical practice. But many continue to use the sphygmomanometer feeling that successive readings in the same patient must record accurately the relative variations of intra-arterial pressure in that individual. But Dr. Russell agrees that the tonicity of

the arterial wall is a variable quantity, and can easily alter the readings of the pressure required to obliterate the arterial lumen. He quotes a case of a woman whose pressure varied to the extent of 130 mm. Hg., and this he attributes to relative degrees of hypertonicity. In short, the author places little trust in the sphygmomanometer as a recorder of blood pressure, while not denying its use intelligently handled.

The final chapter on the estimation of heart power is reprinted from the *British Medical Journal* of 1916, and is a thoughtful article, if somewhat controversial in places. The whole book is based on sound observation, and is one to make the reader think, and therefore to be recommended to students who are at all interested in the subject. Numerous actual cases are quoted, giving an additional value to the discussions on the various conditions that are dealt with.

Materia Medica with Notes on Prescription Writing. By James Burnet, M.A., M.D., Ch.B., M.R.C.P. Edin. Students Synopsis Series. (Messrs. J. and A. Churchill, London, 1921.) Price 4s. 6d. net.

Messrs. Churchill are indefatigable in their efforts to simplify the passing of medical examinations by reducing the subjects into easily assimilable form. The task of writing this Synopsis of Materia Medica has been entrusted to Dr. Burnet, who has tackled the job in a thoroughly business-like way. He starts with an alphabetical list of the more important drugs of the pharmacopœia, and under each he gives briefly the source, characters, composition and preparations. Although the book is not intended to include the sister science of pharmacology —another volume of the series is devoted to this subject—we think it would be an improvement if the action of each drug was mentioned quite shortly.

Sections on the B.P. preparations, prescription writing, incompatibilities and solubilities, make the work into a very complete volume, which is well up to the standard that we are accustomed to expect from the House of Churchill.

Syphilis and Venereal Diseases. By C. F. Marshall, M.D., M.Sc., F.R.C.S., and E. G. Ffrench, M.D., Ch.B., F.R.C.S.Edin. Fourth Edition. (Messrs. Ballière, Tindall & Cox, London, 1921.) Price 25s. net.

The new edition of this work has profited much by the vast experience that was gained in the treatment of venereal diseases during the war. It is doubtful if any branch of therapeutics derived greater advantages from the opportunities of accurate observation provided by war conditions and the co-operation of Dr. Ffrench in the production of the present edition of this work, has enable much of the experience so gained to be incorporated in Dr. Marshall's book. A striking feature of the book is its completeness and the fact that the personal views of the authors are always given with fairness and with no attempt to be dogmatic upon points upon which there is still some dispute.

We notice that Dr. Ffrench claims to have confirmed McDonagh's view that the "infective granules" represent a spore stage in the life history of the spirochæte. The chapter on laboratory diagnosis, written with the assistance of Dr. Shera, will prove a great boon to those practitioners and students to whom the technique of these precedures is unknown or insufficiently understood. The illustrations, too, are of high standard, though it is a pity that the pictures of urethroscopic appearances could not be given in colour. The case of that rare condition, Keratodermia Blenorrhagica, which is illustrated on Plate VII., is hardly as good as the one that was recently in Stephen under Dr. Fawcett.

We are glad that the authors have a good word to say for the value of mercurial treatment, but they are not very clear on the exact dosage to be used in the routine administration of N.A.B.

Practitioners will be interested in the tests for the cure of gonorrhœa on page 412. The authors are inclined to the belief that the complement fixation test is likely to prove the most valuable of these.

Finally, it is exceedingly satisfactory to find that, in the last chapter on Venereal Disease and Public Health, the authors advocate the doctrine of immediate self disinfection as the best method of preventing the spread of these diseases, thus upholding the policy of the National Society for the Prevention of Venereal Disease. We know of no work dealing with the pathology, symptoms and treatment of these diseases in a way better adapted for the student who has no time to refer to the larger text-books.

Abstracts of Current Medical Literature.

Acute Pancreatitis.

The *Lancet* for July 16th, 1921, contains two articles on this subject. (i.) A. T. Compton and F. Heber, after referring to an analysis of 50 cases re-

corded between 1910 and 1920 in various British journals, describe three cases which came under the authors' observation.

In Case I. the pancreatic swelling was incised and drained. The article contains observations, made by F. Heber, on the fluid obtained from the fistula. Case II. had a history of gonorrhœa and stricture. A hard, elongated body running across the left kidney was found at operation. Case III. was one of acute hæmorrhagic pancreatitis.

(ii.) R. B. Carslaw describes a case of acute pancreatitis. At the first operation bile and calculi were removed from the gall blader. At the second a cyst of the tail of the pancreas was opened. Recovery.

Pathogenesis of Hæmorrhagic Pancreatitis.

The *Lancet* for July 16th (French Supplement), contains an article by L. Binet and P. Brocq on this subject.

Nature of Internal Secretion of Pancreas. (*Dublin Journ. Med. Science*, July, 1921.)

W. M. Crofton considers that the internal secretion is not a hormone, but "an essential part of a compound ferment by means of which . . . anabolism and katobolism of different food materials is brought about."

Lethargic Encephalitis. (*Glasgow Med. Journ.*, July, 1921.)

M. Mandon discusses a few of the eleven cases admitted to Rushill Fever Hospital between April, 1919, and January, 1920. Where lethargy and asthenia predominate over more definitely localised symptoms, the outlook is serious. The author discusses the ætiology, diagnosis, and prognosis of the disease, and the therapeutic value of serum from convalescent patients.

The Control of Hæmorrhage by Intramuscular Injection of Calcium Chloride. (*B.M.J.*, July 9th, 1921.)

W. R. Grove and A. W. C. Vines, after referring to an article by W. R. G. in the GUY'S HOSPITAL GAZETTE of May 18th, 1918, in which it was pointed out that credit for the use of the drug is due to Dr. W. E. Dixon, publish a short statement of their results. A full report will be issued later.

The authors recommend the injection of 1 grain of calcium chloride in 10 minims of water deep into the gluteal muscles. A second injection may be given safely at the end of 24 hours.

Malignant Granuloma of the Nose. (*B.M.J.*, July 16th, 1921.)

Sir R. Woods describes two cases. The disease is characterised by ulceration of the walls of the nose, with the formation of glutinous crusts. There was a peculiar fœtid odour. Granulation tissue was the dominant feature in specimens of the ulcerated surfaces. In one case there was a resemblance to sarcoma.

Anti-syphilitic remedies were of no use. The Wassermann was negative in each case. Case I. died. Case II. was cured by radium. There are illustrations of the cases.

Cæsarian Section. (*Ibid.*, July 16th.)

Arnold Jones pleads that Cæsarian section should be performed more frequently than is the case at present. He describes a new operation, in which the use of a form of gridiron incision into the uterine walls, leaves a scar which will stand the strain of future pregnancies.

Tuberculosis of Tonsils. (Archives of Internal Medicine, Amer. Med. Association, June 15th, 1921.)

C. V. Weller surveys the results of a microscopic study of approximately 9,000 cases dealt with by the University Hospitals in Michigan. He concludes that the systematic search of microscopic sections is the only practical routine method for detecting tonsil tuberculosis. The incidence was 2·35 per cent. The affection was slightly more common in females, and ages ranged from 2 to 59 years. The author divides tonsil tuberculosis into three types: focal crypt infections, ulcerative lupus-like lesions, and diffuse miliary tuberculosis. The crypt infection is the most common type. There is an extensive bibliography.

Surgical Diathermy. (*Amer. Journ. of Surgery*, June, 1921.)

G. Kolscher describes the technique of diathermy and discusses its application to tumours in various parts of the body. There are five diagrams illustrating the treatment. Attention is drawn to the value of a combination of diathermy and X-ray therapy.

Lumleian Lecture on Some Points in Actiology of Skin Diseases. (Lecture II. *Lancet*, July 16th, 1921.)

Dr. Whitfield deals with some of the internal factors in the production of skin diseases. He dis-

cusses sensitization under two headings: auto-sensitization and foreign protein sensitization. Gastro-intestinal errors are considered, and Drs. Ryle and Barber quoted, the author disagreeing with the latter in his clinical description of rosacea. Indicanuria is considered an indication for treatment with creosote. Similarly the presence of bile salts in pruritis is an indication for the use of thyroid extract. Dr. Danysz's view that anaphylactic immunity is a cause of many chronic diseases of non-parasitic origin is criticised. The author concludes with a paragraph on the association of *cholesterolæmia* and *xanthoma*.

Appointments.

Guy's Hospital Medical School.

July 16th—October 15th, 1921.

Surgical Ward Clerk.—Messrs. E. W. Annis, M. H. Ashwin, D. H. Berry, W. H. Bradfield, A. Canard, L. W. Cann, R. J. Cann, R. S. Chambers, H. G. Close, A. S. M. Douglas, R. D. Gross, J. C. Hewetson, G. C. Hughes, I. M. Hurwitz, C. Ive, R. E. Lane, S. A. Leader, F. Marsh, O. G. Morris, H. Maclachlan, L. E. Owen, W. F. Payne, C. H. C. Troussaint, D. S. Todd-White, I. R. Vermooten, J. L. Walker, S. C. H. Worseldine, H. D. Wyse.

Clerks to Medical Unit (first three months).—Messrs. T. S. Blacklidge, W. A. Caldwell, A. R. Cox, J. A. Currie, A. B. Davies, G. F. Gibberd, L. G. Housden, S. P. Jacobson, D. J. T. Jeans, J. Jemson, Emrys Jones, C. E. Keast, G. C. Millis, G. O. Mitchell, P. McG. Moffatt, E. E. Neser, F. N. Newell-Roberts, G. Owen, G. W. V. Parry, A. T. W. Powell, S. C. Rowbotham, H. C. C. Taylor, D. Vaughan.

(Second three months).—(Dr. Fawcett, Dr. Ryle and Dr. Marshall) Messrs. W. A. Brown, H. Meathrel, M. Weinbren, C. O. Carson, A. F. Percy, N. H. M. Lloyd, I. E. Harries, W. G. Booth, A. Broide, R. J. Hooker; (Dr. Beddard and Dr. Mutch) Messrs. H. Canning, J. Woodhouse, B. Woodroffe, S. H. Daneel, P. G. Harvey, A. B. Aldred, R. Brooke, G. B. Withers, E. Orsmond, R. M. L. Still; (Dr. Hurst and Dr. Hunt) Messrs. D. H. Hubbs, P. Hack, H. Plowright, H. Bernstein, J. Denyssen, H. Evans, A. Gordon, D. Robinson, S. Suzman, C. W. Warne.

Dressers to Surgical Unit (first three months).—(Sir A. Fripp and Mr. Turner) Messrs. H. C. Beccle, M. Bannounah, M. Mitman, T. Wooldridge; (Mr. Steward and Mr. Hughes) Messrs. N. Eckhoff, —. Hitchings, N. L. Lloyd, F. Graham-Bonnalie, T. A. Shaw; (Mr. Fagge and Mr. Davies-Colley) Messrs. C. G. Bowen, —. M. Killard-Leavey, —. Seelenfreund; (Mr. Rowlands, Mr. Bromley and Mr. Slesinger) Messrs. R. H. Amm, J. L. Faull, R. G. Tame, G. D. Shaw, M. Hawke, D. Crawshaw.

Second three months).—(Sir A. Fripp and Mr. Turner) Messrs. G. R. Apsey, C. Atkinson, G. M. Stoker, G. E. Fisher, D. Whitlock; (Mr. Steward and Mr. Hughes) Messrs. E. Boland, D. S. Davies, F. J. Biddle, E. Koerner, H. J. Wood; (Mr. Fagge and Mr. Davies-Colley) Messrs. F. J. Smith, L. Forman, F. Ratnagar, J. Linklater, —. De Boissiere, —. Honigsberger; (Mr. Rowlands, Mr. Bromley and Mr. Slesinger) Messrs. M. Jackson, M. Markiles, S. Bakhle, A. W. Hall, C. Probert, J. Atkin.

Obstetric Dressers, Extern, and Clerks in the Children's Department.—(Mr. Chapple) Messrs. R. Hale-White, F. D. Howitt, C. Kark, D. G. Sharp, D. A. Windelmer, J. S. Hudson, H. V. Croucher (not Extern), and H. T. Chiswell; (Mr. Bellingham-Smith) Messrs. P. G. Sedgwick, W. G. R. Hore, L. H. B. McLeod, W. M. Ramsden, C. A. Marais, C. F. Parry, and C. C. Po.

Dressers in Special Departments.

Ophthalmology.—(Mr. Eason) Messrs. M. E. Shaw, H. B. Jones, and M. A. El-Biblawi; (Mr. Ormond) Messrs. T. E. Jones, J. K. Milward, and G. B. Kirkland.

Laryngology.—(Mr. Layton) Messrs. M. E. Shaw, H. B. Jones, and A. T. Rogers; (Mr. Mollison) Messrs. T. E. Jones, J. K. Milward, and A. H. Douthwaite.

Dermatology.—(Dr. Barber) Messrs. B. L. Laver, H. A. Harris, F. Widgery, and M. Mackenzie.

Neurology.—(Dr. Symonds) Messrs. J. Alexander and D. Davies.

Genito-Urinary.—(Mr. Thompson) Messrs. J. Alexander and D. Davies.

Fractures.—(Mr. Slesinger) Messrs. A. R. Patel and C. Shepherd.

Orthopædics.—(Mr. Trethowan) Messrs. A. R. Patel and C. Shepherd.

Clinical Assistants to Dr. French.—Messrs. M. H. Mackeith, R. J. Hodgkinson, E. H. Richards, L. R. A. Wells, E. Hardy, and L. Rosenberg.

Pathological Assistants to the Demonstrators of Morbid Anatomy.—Messrs. M. Mitman, and J. K. M. Lloyd.

G. T. Mullally, M.C., M.S., F.R.C.S., to be Assistant Surgeon to Mount Vernon Hospital for Consumption and Diseases of the Chest.

Guy's Hospital

The following appointments and reappointments have been made by the Treasurer upon the recommendation of a Staff Meeting. (To date from October 1st, 1921.)

Medical Registrars.—Mr. J. J. Conybeare, Mr. G. B. Dowling.

Medical Assistants.—Mr. W. H. Grace (Dr. Fawcett); Mr. A. A. Osman (Dr. Hurst).

Surgical Registrars.—Mr. J. Joffe, Mr. C. S. Lane-Roberts.

Surgical Assistants.—Mr. T. G. D. Bonar, Mr. W. E. Tanner.

Midwifery Assistant and Registrar.—Mr. A. J. McNair.

Gynæcological Assistant and Registrar.—Mr. F. Cook.

Chief Clinical Assistants and Registrars—

Neurological Dept.—Mr. J. M. H. Campbell.

Throat and Ear Dept.—Mr. J. Joffe (Mr. Layton); Mr. N. E. Kendall (Mr. Mollison).

Ophthalmic Dept.—Mr. C. H. St. John (Mr. Eason).

Orthopædic Dept.—Mr. A. H. Todd.

Children's Diseases.—Mr. A. A. Osman.

Actinotherapeutic and Electrical Dept.—Mr. J. F. Carter-Braine.

Assistant Anæsthetists.—Mr. N. E. Kendall, Mr. R. B. P. Lansdowne, Mr. P. D. Scott.

Anæsthetist to Bright Ward.—Mr. T. G. D. Bonar.

Anderson Demonstrator of Clinical Chemistry.—Mr. W. W. Payne.

Demonstrator of Clinical Chemistry.—Mr. J. J. Conybeare.

Demonstrators of Pathology.—Mr. E. Biddle, Mr. C. S. Lane-Roberts.

Demonstrator of Morbid Histology.—Mr. E. W. Bowell.

Jun. Asst. Bacteriologist.—Mr. E. Biddle.

Demonstrators of Anatomy.—Mr. Grant Massie (whole time); Mr. T. G. D. Bonar, Mr. J. F. Carter-Braine, Mr. R. C. B. Ledlie, Mr. J. Gaymer Jones (part time).

Demonstrators of Physiology.—Mr. W. H. Grace, Mr. W. H. Ogilvie (part time).

Demonstrators of Chemistry.—Mr. G. M. Bennett, Mr. H. C. Bell (whole time).

Demonstrator of Physics.—Mr. T. W. Adams (whole time).

Demonstrator of Biology.—Mr. L. C. Fox.

Demonstrators of Prosthetic Dentistry.—Mr. J. R. Herbert, Mr. H. L. Messenger.

Demonstrators of Operative Dentistry with charge of Probationary Classes.—Mr. A. B. Aldred, Mr. H. G. R. Canning, Mr. A. L. Spencer-Payne (mornings); Mr. J. A. S. Wright, Mr. E. H. Bryant, Mr. H. Millett (afternoons).

Dental Radiographer.—Mr. H. M. Worth.

Assistant Anæsthetists to the Dental School.—Mr. E. R. Bailey, Mr. F. W. Crook, Mr. A. L. Spencer-Payne.

Dental Bacteriological Assistant.—Mr. A. Bulleid.

Director of Dental Prosthetic Laboratory.—Mr. W. Kelsey Fry.

Dental Officer to Salomon's Infant Welfare Centre.—Mr. E. R. Bailey.

Notices.

Universities' Library for Central Europe

(In co-operation with the Universities' Committee, Imperial War Relief Fund).

President: The Right Hon. Viscount Bryce, C.B.
Chairman: Sir W. H. Beveridge, K.C.B., M.A., B.C.L.
Treasurer: Lt.-Col. George Schuster, C.B.E.

INTELLECTUAL FAMINE RELIEF FOR CENTRAL EUROPE.

"*I found a people hungering in mind and soul for contact with the intellectual world outside.*" Thus wrote a representative of the Universities' Library after a recent visit to the Continent. English books are practically unobtainable on the Continent owing to the state of the Foreign Exchanges. The Universities' Library for Central Europe, has, during the past year, sent more than 2,500 treatises, and a much larger number of scientific periodicals, reviews and transactions to its various centres on the Continent. Thousands more

must be obtained and sent, if the intellectual starvation prevailing everywhere is to be allayed. The above Library has received requests for 20,000 specific works in English which are most urgently required. A representative of the European Student Relief Scheme (through whom the Universities' Committee and this Library are distributing all help given to students) writing on 19th May, 1921, from Poland, says:—

> "The situation in regard to elementary textbooks and the essential reference books in medicine, engineering, agriculture and the classics of English literature is appalling; great as is the physical distress, it is not felt so keenly by this highly intellectual people as is this mental starvation. I must not delay sending you an S.O.S. for textbooks for students, especially in medicine. Any books you may forward will be used by literally scores or even hundreds of eager students."

Austria reports:—

> "The want of English and American literature is most severely felt. There is imminent danger of our being separated from the scientific and technical world, *a thing which would imperil the unity of civilization.* We are faced with the impossible task of how to get hold of foreign literature."

Czechoslovakia urgently requires recent books and publications relative to the study of English language and literature. Hungary is in dire need of technical, medical, legal and philosophical works, especially scientific and technical periodicals. Esthonia desperately needs works of English poets, novelists, essayists and historians. Finland and Roumania are crying out for books which we cannot provide because of our lack of means. Particulars of special requirements of particular places will be gladly sent on application being made to the Secretary.

Nearly everyone has books for which he has no further use, and which would be highly valued in Central Europe. If every student on leaving college this term would hand over at least two books (or ten shillings to purchase two) as a thank-offering for the good time he has had at his studies, it would be a tremendous help towards providing a similar good time for the students of Continental universities.

Books of any kind, and money for the same, should be sent to the Secretary: B. M. HEADICAR, *Universities' Library for Central Europe, London School of Economics, Clare Market, Kingsway, London, W.C.* 2.

Cricket.

Final Inter-Hospital Cup Tie.

GUY'S v. ST. THOMAS'S.

This match was played at Honor Oak Park on Thursday and Friday, July 14th and 15, 1921, resulting in a win for Thomas's by 46 runs, after a most interesting game.

Thomas's won the toss, and sent in Weaver-Adams and G. H. Cooper to face Van Schalkwijk and Shaw. Thomas's were finally dismissed for 271, out of which Weaver-Adams scored 137.

Guy's started none too well, Willis being sent back by an excellent ball from Berridge, but a stand by Shaw and Rose put the Hospital in a better position. At close of play the Hospital were 7 wickets down for 191. Stuart and Ensor continued on Friday morning, and the score was taken to 228 before the side was dismissed.

The second innings of Thomas's was sensational. At lunch time 4 wickets were down for 102 runs, but on resuming, Biddle and Wooldridge, bowling extremely well, got the remaining 6 wickets for 6 runs. This gave our opponents 110 total, leaving the Hospital 159 runs to get. With the exception of a stand by Helder and Wooldridge, none of our batsmen could do anything with the bowling of Berridge and Humfrey, and the side was out for 112, Thomas's thus winning by 46 runs.

St. Thomas'.

First Innings.

E. K. Weaver-Adams, b Stuart	137
G. H. Cooper, c May b Van Schalkwijk ...	0
S. Farquharson, b Biddle...	26
W. C. M. Berridge, b Van Schalkwijk ...	19
J. Hale, c and b Shaw	1
S. H. G. Humfrey, b Shaw	4
G. Cranstown, b Biddle	18
M. H. Webb-Peploe, b Van Schalkwijk ...	5
J. L. Farquharson, b Ensor	49
J. C. Haward, not out	0
Extras	12
Total	271

Did not bat: J. H. Doggart.

Bowling (first innings):—J. Van Schalkwijk, 3 for 79; G. D. Shaw, 2 for 65; T. Wooldridge, 0 for 35; F. J. Biddle, 2 for 45; G. M. Stuart, 1 for 25; A. G. Ensor, 1 for 10.

Guy's.

First Innings.

L. C. Willis, b Berridge	2
G. D. Shaw, c and b Berridge	39
S. Rose, b Humfrey	52
L. B. Helder, b Humfrey	34
T. Wooldridge, b Humfrey	1
A. G. Ensor, not out	42
G. L. Shearar, c Cooper b Humfrey ...	6
J. Van Schalkwijk, c Webb-Peploe b Haward	13
G. M. Stuart, c Cooper b Humfrey... ...	11
F. J. Biddle, c Webb-Peploe b Berridge ...	3
R. C. May, b Humfrey	1
Extras	19
Total	223

Bowling (first innings):—Berridge, 3 for 109; Humfrey, 6 for 87; Haward, 1 for 5; Doggart, 0 for 3.

St. Thomas'.

Second Innings.

E. K. Weaver-Adams, b Wooldridge	30
G. H. Cooper, lbw Wooldridge...	18
S. Farquharson, b Wooldridge...	34
W. C. M. Berridge, b Biddle	11
J. Hale, b Biddle	1
S. H. G. Humfrey, c and b Biddle... ...	2
G. Cranstown, b Biddle	1
M. H. Webb-Peploe, b Wooldridge	2
J. L. Farquharson, c Rose b Wooldridge ...	0
J. C. Haward, not out	0
J. H. Doggart, c Shaw b Wooldridge ...	0
Extras	11
Total	110

Bowling (second innings):—Biddle, 4 for 30; Shaw, 0 for 27; J. Van Schalkwijk, 0 for 24; T. Wooldridge, 6 for 14; G. M. Stuart, 0 for 4.

Guy's.

Second Innings.

L. C. Willis, c Humfrey b Berridge	0
G. D. Shaw, b Humfrey	12
S. Rose, b Berridge	2
L. B. Helder, c Berridge b Doggart... ...	23
T. Wooldridge, c Cooper b Berridge... ...	44
A. G. Ensor, b Haward	2
G. L. Shearar, b Haward	2
J. Van Schalkwijk, c Cooper b Berridge ...	14
G. M. Stuart, c Hale b Haward	6
F. J. Biddle, c Cooper b Berridge	0
R. C. May, not out	1
Extras	6
Total	112

Bowling (second innings):—Berridge, 5 for 31; Humfrey, 1 for 29; Doggart, 1 for 14; Haward, 3 for 10.

Lawn Tennis.

The Nurses' Inter-Hospital Tournament.

Guy's played their second tie in this tournament on July 6th. Our opponents were the nurses of Joyce Green Hospital, who proved no match for the teams which we sent against them.

Nurse Stubbs and Nurse Johnson were opposed to the stronger pair of players, and by steady and skilful play won all three sets of their match, the scores being 6—3, 6—3, 6—1. In the second match Nurse Vian and Nurse White completely outplayed the Joyce Green team, winning three consecutive love sets.

Specialities.

Sterilized Maternity Outfits.

SISTER E. BOLLAND, A.R.R.C., 100A, ADDISON GARDENS, LONDON, W. 14.

Every Maternity Nurse would do well to get into communication with Sister E. Bolland at the above address, who is now supplying sterilized Accouchments Outfits. They are the best and cheapest we have yet seen. Carefully packed in a nice cotton wallet, the Nurse will find everything she needs—nothing is forgotten. The list is too long to print here, but from the smallest to the largest requirement, everything is there at hand. Sister E. Bolland (who is a member of the College of Nursing) is also supplying special Accouchment Sets to suit the individual needs of medical men and nurses. A postcard will bring all particulars.

Birth.

MULLALLY.—On the 9th July, at 4, St. Thomas' Street, S.E., the wife of G. T. Mullally, of a daughter

Marriage.

SAWDAY—AMOS.—On July 14th, at Brackley, Northants, A. Ernest Sawday, of 123, Osmaston Road, Derby, to Winnifred Amos.

ED.—A. T. R.

GUY'S HOSPITAL GAZETTE.

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Passim.

THE supplement to the *British Medical Journal* for July 23rd, 1921, contains a report of the eighty-ninth annual general meeting of the British Medical Association, held at Newcastle-upon-Tyne.

From the point of view of general interest perhaps the *pièce de resistance* of the proceedings is a discussion upon the constantly recurring problem of professional secrecy, which we venture to suggest is well worth perusal. Everyone should read this for himself, as it provides food for thought upon one of the most intimate aspects of our professional life.

The meeting finally passed by a large majority an amendment to the original motion, and the conclusion finally reached was that the Association would support to its utmost any medical man who refused to divulge, without his patient's consent, information obtained in the exercise of his professional duties, except where it was already provided by Act of Parliament that he must do so.

It must be obvious, to any intelligent person, that there are occasions upon which the otherwise inviolate rule of professional secrecy must be broken. A murder, for instance, supplies a case in point. Secrecy would not be for the good of the general public, and no doctor would be *particeps criminis*. Hippocrates himself recognised the necessity for exceptions to the general rule. But the attempt, which is being made, to encroach upon the number of these exceptions, must fill all medical men with the gravest concern and resentment.

The particular group of cases which is prominent at present is that of patients attending venereal clinics. If doctors are to be forced to disclose information obtained in such cases, the feeling of the layman that he can trust his doctor will disappear, and cases will go untreated because the promise of secrecy held out by the traditional tenets of our profession is no longer to be relied upon.

SPEAKERS at the meeting drew attention to the fact that there was no law to prevent Courts from forcing priests or lawyers to betray the confidences of their parishioners or clients. Yet priests and lawyers are not asked to divulge these confidences, simply because it is known that they will refuse.

Medical men should be in the same position. No statute is necessary. If it is found that doctors invariably refuse to speak, when it is improper to do so, they will not be asked to speak.

We might term this a process of education of legal authorities. There are many other questions upon which the general public might be better informed.

Lord Goschen, speaking at our Annual Prize-giving, referred to the necessity for maintaining an interest in, and understanding of, medical problems on the part of the laity.

The almost universal objection to post-mortems is a case in which lay prejudice—and very natural prejudice—often hinders doctors in their work.

We read in a lay periodical, lately, a poem protesting against the proposed "bureaucratic action" involved in making a post-mortem compulsory, when the doctor thinks it necessary. Surely a better method of producing a different attitude towards post-mortem investigations would be to educate public opinion, by various means, in such a way that the laity appreciated their value. The ideal condition would be one in which consent to an autopsy was always forthcoming—not one in which the consent was never asked for, being legally unnecessary.

We publish on p. 312 a letter from a correspondent, "Registrar," urging that greater opportunities should be given for dressers to obtain experience of acute Surgical "Take-in" work. Our correspondent considers that the whole firm, not merely the two dressers on duty, should live in during their firm's "take-in," and that dressers should be given a priority claim in obtaining rooms in the College.

While we cordially agree with "Registrar's" views upon the value of experience, we know of many men who would not care to live in the College, even if they had the chance. Such, for instance, are many men who live at home. Still, they should be given the option.

As regards accommodation for the Take-in Ward Clerks, we agree that it is time something was done. One suggestion that we can offer is the reservation of certain rooms in the College, for the sole use of the Take-in firm. Is this project likely to be practicable?

Among other suggestions which have reached us is one that sleeping rooms in the Front Surgery should be re-arranged.

Accommodation for the R.S.O. could be found in the College, thereby freeing two rooms over the surgery for the use of dressers and ward-clerks. It is also suggested that the large bedroom at present used by the A.H.S. for the week should be available for two dressers or ward-clerks, the A.H.S. being housed in one of the dresser's bedrooms.

There are possible objections to both of these suggestions, and we shall be glad to hear other people's views on the subject.

The Lawn Tennis VI. are to be congratulated on their success in the final cup-tie against St. Bartholomew's Hospital on July 31st. Guy's won by 8 matches to 3. The first three singles went to the visitors; but Guy's won all the remaining matches except one, which was unfinished, and three which were not played.

Thus both the Lawn Tennis Cups will repose in the College Smoking Room this year, the 2nd VI. having won the Junior Inter-Hospital final cup-tie some weeks ago.

In the Inter-Hospital Nurses' Lawn Tennis, Guy's team won the semi-final against St. Marylebone Infirmary. We wish them the best of luck in the final.

The past week has been a week of cricket, but no accounts of the matches are to hand at the moment. In the Past v. Present Guy's match, the Present won by about 140 runs in the first innings, and the Past followed on. The second innings was not finished. We hope to publish an account of this match in our next issue.

While on the subject of sport, we cannot refrain from a few words of entreaty to the Secretaries of the various sports clubs. In the Clubs' Union Year Book is an account of the scope and activities of the Gazette. As the recognised organ of the constituent institutions of the Clubs' Union, it should contain, besides scientific matter, and other contributions of interest, accounts of sport, "furnished by the secretaries of the respective clubs."

Some secretaries furnish these accounts very willingly and readily, but there is, on the whole, a tendency to believe that the endless chasing around which is necessary in eliciting reports of games is an essential part of the duties of an editor

It is quite possible that this is the case. It is also probable that it does us good. But it is only human to prefer some easier way of doing things.

If each secretary sent in accounts of matches as soon as possible after the events, without having to be asked for them, matters would run very smoothly indeed, and it would be certain then that no athletic event of importance was overlooked. As things are at present, there is a danger that some sports may receive an unfair prominence, while others receive but scant recognition.

And we would conclude this little homily by drawing attention to the facts that copy is always better when written in ink, and that printers prefer reports to be written on one side of the paper only.

We offer our sincere congratulations to Mr. Alan H. Todd, who was recently appointed Hunterian Professor of the Royal College of Surgeons for February, 1922, when he is to give a lecture on "Orthopædic Aspects of Rheumatoid Arthritis." He has also just received a grant from the British Medical Association towards a research into the ætiology, pathology, and treatment of toxic arthritis and allied conditions.

We are also very glad to hear that Mr. J. V. C. Braithwaite was successful in the recent examination for the M.R.C.P. This is particularly creditable in view of the fact that he obtained this diploma while still a House Officer.

The death of William Kellock McKay, in Persia, will be a great blow to those who had the privilege of knowing him intimately.

A short but impressive memorial service held in the Chapel on Thursday, July 28th, was attended by many of his friends still at the Hospital. At the conclusion of the service Chopin's Marche Funèbre, that most beautiful of funeral marches, was played.

We publish an obituary notice elsewhere in this issue. We offer our deepest sympathy to his relatives in their great loss.

We have received a notice drawing attention to the fact that the University of London O.T.C. Roll of War Service has now been published. It is hardly likely that the impecuniosity prevalent among medical students will allow many to buy a copy of this volume, which costs one guinea.

Should any affluent gentlemen be in a position to do so he will find much that is of interest. Apart from the statistical information it contains, those of us who were in the O.T.C. before serving in France will be able to look up the names of old comrades.

The first section is devoted to the Roll of the Fallen, the second records honours and distinctions obtained, the third contains a Roll of

War Service with particulars of the members of the contingent who served as officers in the war, while the fourth is historical and statistical.

Some of us have memories, happy or the reverse, according to our ability, of forming fours, and, later, making other people form fours, under the direction of a peculiarly candid sergeant at South Kensington. For such as these the names in this volume will revive recollections of many a preliminary excursion into the realms of military art, before embarking upon the more serious journey abroad.

J. A. C.

Obituary.

WILLIAM KELLOCK McKAY.

In October, 1909, there entered Guy's a very unassuming, almost shy, student who few believed was destined to play so intimate a part in the daily life of the hospital.

The son of an old Guy's man, Col. H. K. McKay, C.B., C.I.E., I.M.S. (who was house-surgeon in 1870), William Kellock McKay was born on August 17th, 1890, at Jubbulpur in India. He came to England at an early age, and after his preliminary education at Shirley House School, Blackheath, he entered Cheltenham College, where he was awarded several prizes for general distinction.

On entering Guy's he at once made many friends who were attracted to him by his strong and sympathetic character—his worthiness is not to be sought in the record of academic distinctions. He made no pretence to brilliancy, preferring always to steadily plod the rougher path of thoroughness and soundness. As a dresser he was held in high esteem by his colleagues, and it is certain that his opinion was appreciated by many of his seniors. He had already begun to show his capacity to understand and to deal with his fellow men with tact and kindliness.

He considered no task too menial, and he was ever willing to lend a hand and seemed always to enjoy whatever task he was called upon to perform. He never allowed anyone to feel his social inferior; he was always most courteous and pleasant—what wonder then that not only his immediate colleagues, but all those with whom his daily work brought him in contact esteemed him so highly. In 1913 he met with a motor cycle accident, and lay for a long period in a most critical condition. On his recovery it was considered inadvisable for him to continue his medical studies without a long rest. With his parents he travelled to Canada, and early in 1914 he enlisted in The Royal North West Mounted Police. In this service he gradually returned to health again; he liked the great open northern chines over which he roamed; he admired the more simple virile type of man with whom he had to deal. His knowledge of men and his capacity to understand them stood him in good stead, and within a year he had firmly established a reputation in this service.

At the beginning of 1916 he felt that he had completely recovered and wished to respond to the great call made by the Mother Country to her Colonies.

On applying for permission to resign from the service he was met by a refusal, as men, and especially men of his calibre, were none too plentiful in these northern outposts. He thereupon determined to desert. With his knowledge of the country he easily reached White Horse, Yukon, but being well known to all he experienced great difficulty in crossing the border into Alaska. He now travelled to New York where he narrowly escaped capture as an order for his arrest had been issued, and his furs and mocassins (which want of time had prevented him from exchanging for other garments), made him an easy suspect. In these same garments he travelled steerage to England. Immediately on his arrival he joined the 1st King Edwards' Horse which was then training in Ireland, and was soon sent to France. After some 20 months service abroad he was placed in class W of the reserve and returned to Guy's to continue his medical studies. In spite of his long absence he still found some old friends who welcomed him with open arms and no little surprise. He now found it necessary to finish one or two appointments before he could qualify. How difficult and uninteresting this must have been to a man whose life had often, during the last four years, hung by a thread, can only be appreciated by those of his friends who had heard him narrate some of his adventures. Yet he was never heard to grumble or bemoan his fate, and to all outsiders he appeared to be thoroughly enjoying his return to medicine. He qualified early in 1919 and

WILLIAM KELLOCK MCKAY, M.R.C.S., L.R.C.P.

was appointed Assistant House Surgeon to Mr. Bromley. As house officer he showed that he had lost none of those virtues which he took to Canada. He refused to share or split the responsibility of the patients that were not doing well. He took full blame (very often unjustifiably) for the accidents which occurred; he was never heard to boast, although as a contemporary resident the present writer knows that there were many occasions on which he might well have claimed to have been the main factor in getting the patient well. He now became house-surgeon to Mr. Steward, and was almost unanimously elected president of the residents.

During the preceding years (1917 and 1918), owing to the general disorganisation of the resident appointments, the prestige of the residents had fallen considerably, and McKay immediately set himself the task of remedying this. It will surprise the reader but little to hear that by the time his tenure of office had elapsed he had successfully re-established the pre-war standard of this prestige.

It is safe to say that at this period there wa not a person in the college who bore him an ill thought, for he had offended none, and befriended others whom fortune had treated less kindly. He now experienced a severe attack of *wander lust*, but was dissuaded from leaving the hospital and became Ophthalmic House-Surgeon. It seemed not to matter what duties he was called upon to perform, for he always gave universal satisfaction.

Early in 1920 his love of travel declared itself in a visit to Rio de Janeiro, whence he travelled as ship's doctor. On his return he was attracted to the East and applied for the post of Assistant Medical Officer to the Anglo-Persian Oil Company, to which he was appointed towards the end of the year. Being determined that the Company should not lose by his lack of experience in tropical medicine, he attended the London School of Tropical Medicine, and acquired a large fund of such knowledge as would prove of value to him in Persia. He went East in February, 1921, and although he wrote to few, and those but seldom, it is known that he found his new work full of interest; that he believed the country not so infested with disease as he had anticipated, and that he was, in fact, encouraging a contemporary resident to accept a similar appointment. He did not apparently miss the conventions of the West and found the mode of living to his liking.

The details of his death are not yet known; his work necessitated exposure to the sun in the middle of the day, and he was attacked by heat stroke. To this he rapidly succumbed.

And so another Guy's son—a gentleman of nature—has perished in the practice of his art. His deeds may fire no bard, but to a large circle of friends he will always be remembered as one of the very best.

Notes on an Interesting Case.

The following case is, I think, of sufficient interest to bring before your readers.

The patient, J. F., an ex-soldier aged 35, and in civil life a groom, was seen on January 21st, 1921. He gave a medical history as follows: He had appendicitis in 1914 for which he was operated on, only being in hospital three weeks; afterwards he was sent to do farm work wearing an abdominal belt. Discharged from military service in August, 1919. In May, 1920, he was admitted to a hospital with a ventral hernia and was again operated on, leaving hospital in June. He was, however, ill at home and did not get back to his work as a groom until the autumn, 1920. Early in January, 1921, he had to give up work and was told another operation was necessary. About the 14th January he took to his bed and was ordered poultices to chest by his Panel Doctor. On the 19th his wife told me he complained of numbness of legs and right arm, and she noticed the latter was white. The right leg was first painful, and then the left. Patient had been married 8 years. No history of rheumatic fever.

On admission.—He seemed to be pretty well and came in with the idea of an operation on his old abdominal scar, which had stretched. He complained of some pain in calf of left leg, and had a slight cough. Pulse 80.

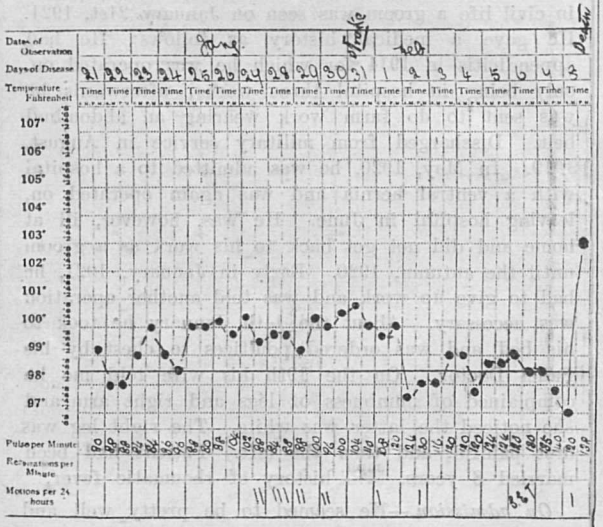
January 22nd, 1921.—Patient still complained of some pains in calf of left leg and some swelling could be felt, which was thought to be probably phlebitis. He remained in bed. The pains and swelling of left leg extended, and at night patient was inclined to be noisy. The heart sounds were noticed to be weak, but nothing abnormal to be heard. It was also noticed he had no pulse at right wrist, but otherwise the arm was perfectly normal. No swelling or pain whatever in that arm.

January 25th, 1921.—Left leg very cold and some subcutaneous mottling noticed on skin. During the night of 30—31, he had a stroke and was found to have no brachial pulse right side, no femoral pulse right or left; paralysis of left arm and left

side of face; tongue moves over to left side; puffing of left cheek; paralysis of left arm, but left pulse could be felt; gangrenous changes of skin of left leg in patches, one near to thigh; urine 1020, slight acidity; albumen a trace.

February 1st, 1921.—General condition the same. Left arm quite paralysed, but pulse good. No pulse to be felt in either right arm or leg. Patient had incontinence of fæces and urine. Conscious, but speaks badly. *Heart.*—The only abnormality was a coupled beat at apex. Dr. Lloyd Roberts, who saw case, dismissed possibility of malignant endocarditis or aneurysm of ascending aorta. No physical signs of latter.

February 3rd, 1921.—Patient a little better, left leg a little warmer. No further extension of skin discolouration on left leg. Temperature, never very high, dropped on 2nd.



February 4th, 1921.—Pulse returned *distinctly at right wrist* and was strong enough to be counted for the first time since patient's admission. Abdominal aorta could be felt close to umbilicus, but neither of its branches; no pulse in either leg. Heart sounds weak, but otherwise normal.

February 5th, 1921.—Pulse in right wrist quite strong. A blood culture previously taken was returned sterile. Wassermann weakly positive. Patient conscious at times; bed sore at back; still incontinent; toes of left leg shrinking up and becoming dark coloured.

February 7th, 1921.—Cheyne-Stokes respiration.

February 8th, 1921.—Left parotid much swollen; mummification of left leg slowly increasing, but no line of demarcation; skin slightly affected on right. Heart sounds feeble; pulse in patient's wrist now disappeared. Rapid breathing; albumen in urine. Patient unconscious. Pupils dilated. He died that morning. Temperature rose to 103° F. before decease.

Post mortem.—Professor Glynn kindly did this.

Respiratory System.—Some fluid in left pleura, none in right. Both lungs œdematous; no infarcts.

Circulatory System.—Externally—Left ventricle slightly enlarged; no pericardial fluid. *Internally*—Cavity of left ventricle enlarged; situated at apex there was a thrombus the size of a large walnut, the walls of ventricle near to this were thinned to 1/8 inch and bulging. Thrombus softening in the centre and breaking down. In ventricle also some post-mortem clots. Valves healthy. Right side of heart healthy; aorta healthy, with exception of slight atheroma near to coronary arteries, but the arteries themselves healthy.

Abdominal Aorta.—No atheroma, 2in. above bifurcation a firm clot. On right side the thrombus in external iliac stopped short of Poupart's ligament. On left side was traced down to femoral in Hunter's canal. No thrombus in mesenteric arteries.

Testicles.—No fibrosis.

Kidneys.—Left full of anæmic infarcts; right some infarcts.

Spleen.—A few infarcts.

Brain.—Right middle cerebral artery thrombosed with softening and shrinking of right temporo-sphenoidal lobe. Right internal carotid also blocked inside skull.

The result of swabs taken at the time of post-mortem from clots negative, only a few B. Proteus organism cultivated. Professor Glynn thought that the result of post-mortem was rather against syphilis.

J. H. JONES.

Pass List.

University of London.

SECOND EXAMINATION FOR MEDICAL DEGREES,
July, 1921.

D. H. Berry.
R. J. Cann.
R. S. Chambers.
H. G. Close.
J. C. G. Dickinson.
J. F. Goodenough.
R. D. Gross.
C. S. Hallpike.
H. N. Hearle.
J. C. Hewetson.
E. F. Hewlitt.
L. G. Housden.
C. Ive.
R. E. Lane.
F. Marsh.
W. A. Mill.
G. H. Pitt.
M. B. Seng.
E. C. Seward.
C. H. C. Toussaint.
E. Warnum.
S. C. H. Worseldine.
H. D. Wyse.

"Consideration for our Patients."

DENTAL CLINICAL LECTURE BY
Mr. E. B. DOWSETT.

Gentlemen,—I propose to talk to you this morning about consideration for our patients. It may seem to you perhaps a collection of very simple suggestions that I am going to give you, but at the same time they are of the very greatest importance, and I judge them to be so from what I so very frequently see in the Conservation Room, more frequently than one would wish, namely, a man tearing through his work with little and sometimes no consideration for his patients. Now obviously this is not as it should be, and I do strongly advise you to give every possible consideration to your patients here in the hospital, or afterwards when you get into practice you will find yourselves lacking most lamentably in one of the most important elements of your practice. I remember some years ago a member of the dental staff here, Mr. Badcock, giving an instance of a patient that came to him one day with a most appaling mouth, and nothing had been done in that mouth for many years. But he came across one piece of work, which was a very large gold-filling. It was still a perfect piece of work and it was the only piece of work in that mouth, nothing had been done ever since. The mouth was, except for that one piece of work, a complete wreck. On Mr. Badcock investigating the matter the patient told him that it was entirely due to the discomfort of the operation of placing that large gold filling in the mouth that had prevented him from having anything else done afterwards. Now the natural moral of this is that the patient was so terrified and hurt by the insertion of that big gold filling that it frightened him from dentistry for ever more. I do not mean that you must never put in large gold fillings but they must be put into the proper patient with proper tact and consideration for the patient.

There is another type of patient and one which more frequently occurs—I have had it occur in my own practice—a patient that comes to one and says, "Now I hope you are not going to use the engine, because I have never had it used yet, and I should like the tooth filled by the hand only." As a rule, in these cases the condition of the patient's mouth tells you that this has arisen from a dentist working in the reverse direction and who has fallen too much in with the patient's wishes and has let that patient down badly as well as himself—namely, by not doing his duty. He has had too much consideration for his patient by endeavouring never to hurt the patient at all, and so we find the patient's mouth has become a complete wreck. You can make a patient's mouth a wreck by doing too much or too little; these are the two extremes that I want to point out.

Now this is another incident I have experienced on many occasions. A new patient arrives and says that the previous dentist was such a brute that he did not consider her feelings, and she hopes that you will be better. These are things which are frequently said in practice. Remember that good work is always desirable, but you must temper that with justice and consideration on all occasions. In other words, always think of the utmost welfare of your patient. Remember a very large number—in fact, I might say the majority of patients—who come to you, do so with an enormous amount of dread. This is quite usual, and it is usually our own fault, for reasons which I have already explained to you. What you want to do is to always bear in mind that you must look after the mental condition of the patient as well as the operation on hand. Imagine, for instance, your own feelings supposing you had never had a tooth filled before, when the dentist proceeds to put the engine for the first time upon your tooth, especially if you have no knowledge whatever of the man who is operating upon you, and especially if he happens to have large and clumsy hands. Just incidentally I would advise every dentist and prospective dentist to have a tooth filled periodically, if only for instructional purposes. Remember also when the patient comes to you he is never at his or her best. I might say that they are more apprehensive in a dental chair than anywhere else in the world. Also remember that she may have been suffering most acutely from pain, such as alveolar abscess, or some other acute form of trouble. Pain and suppuration will undermine a patient's constitution in a few days, so much so that the nervous system is unstrung. Under these conditions she is a worse patient than she would be under normal conditions; therefore you must bear that in mind very closely.

Now to get more on to details; up to the present I have perhaps been rather generalising. When a patient first comes into your surgery that is a very important time. It is the time in which you can impress the patient considerably. I should think that in the dental surgery first impressions are more important than anywhere else. A pleasant greeting to the patient, merely passing the time of day, and a sympathetic manner, listening very carefully and sympathising with any trouble that the patient may tell you goes a very long way towards gaining the confidence of the patient. The patient will often go into most minute details of all sorts of troubles, and all the troubles of her relations quite apart from her own particular ailments. I advise you to listen to them all most attentively on the first occasion, however busy you may be. It is that first occasion which is of the greatest importance and will help you very considerably in gaining the confidence of the patient. Treat all with sympathy and make your own conclusions as the conversation proceeds. Then further, having greeted the patient arrange the chair very comfortably for him. The dental chair properly arranged is probably as comfortable a one as any one can find, but uncomfortably arranged is most uncomfortable and a most distressing affair. Therefore take great care to adjust the head and back, and to fix the foot-rest. Such little attentions will help you in obtaining the confidence of the patient. Then you come to examining the mouth, and you want to examine very gently. I have often observed in the Conservation Room and in the Clinical Room, a student examining a mouth for the first time and he will push his fingers and the mirror into the mouth and knock the patient about. It is most detrimental. In such little actions you frighten the patient and make your subsequent operations more difficult for you as well as for your patient. Therefore be as gentle as you possibly can in all your movements. Let every movement be a purposive movement and do not push the mirror or fingers about in unnecessary places so as to unnecessarily upset the patient.

Every tooth that is touched either with a mirror or probe or finger must on the first occasion be touched very gently, because you do not know what is the matter with the patient and you may be striking a tender tooth and giving unnecessary pain. It is *the* thing which strikes the patient more than anything else that you may do, namely, the giving of unnecessary pain, and the patient can generally recognise it.

When you have once touched a tender tooth and recognised that it is tender, do not touch it again until really necessary. This applies also not only to tender teeth, but also with regard to tender spots on the gums. There may be little places which for various reasons are tender to the touch. You may examine little gumboils or periodontitis extending through the surface of the gums which is not necessarily a gumboil. All such places as these on the gums may be tender. Look very carefully around where your finger will pass before you make any definite pressure with your finger, otherwise you may be giving a patient unnecessary pain.

When you have made up your mind what you are going to do in any particular case, tell the patient exactly what you are going to do. In other words, take the patient into your confidence and hope for the best. Always let the patient know, as far as you are able, when you are going to hurt and when you are not going to hurt, and also distinguish between hurting a little and hurting a great deal. Such remarks as these to the patients will help the patients considerably to brace themselves up to bear the pain that you are about to inflict. If you have already gained their confidence you will be aided in this way by letting the patients know what you are going to do.

Then with regard to the use of the engine—this is our greatest trouble of all. Every patient has a fear, naturally, of the dental engine. Their fear, they will often tell you, is not the actual pain that you are going to inflict, but apprehension that something much worse is going to happen because there is an engine working inside the mouth. They have some fear that you cannot stop when the tooth begins to hurt or that it will fly off the tooth and perhaps cut their tongue or cheek. Therefore before you start with the engine on a nervous patient, if a new one, always reassure them that you have perfect control over the engine in every possible way, and demonstrate it by putting a large burr in the head-piece and show with the switch or foot that you can stop the engine immediately that he tells you to. That may seem a little matter and a very simple one, but at the same time it is a very material one and will aid you in getting on with your work.

In all such ways you gradually gain the confidence of the patient. Then supposing the

patient comes to you with a bad tooth which needs a great deal of treatment, possibly painful treatment. With such a case I think it is not advisable with a new patient, and especially a nervous one, to go right ahead with that particular tooth and give the patient all the pain that must be given with that tooth all at once. Do a little with that tooth only, relieving the pain as far as possible, and put in a dressing and leave the tooth for another time. Then, if you like, go on with something that is more simple. In that way you will gain the confidence of the patient, otherwise you may frighten him off, not only you but all dentists for some considerable time. Therefore, broadly speaking, start such a patient with an easy operation. You will frequently come across, of course, patients that are extremely trying and you are absolutely at your wits end how to deal with them. The only advice that one can give is to have an unlimited supply of patience. Not only that, but cheerfulness with it all, in spite of the patient's, what you may call, bad behaviour in the chair. Above all never lose your temper. We vary very much as to whether we are capable of keeping our tempers or not, but the only advice that one can give is to use your utmost endeavour never to lose your temper, although some people are a severe trial. With such people it sometimes happens that they are so apprehensive that they they wilfully deceive you. They are for a time very difficult patients. But you can, if you do exert all your endeavours never to injure them and carry on your work with the utmost care, test them and find whether they are wanting, so to speak. You can touch certain teeth that you know are not tender, or you may scrape the enamel with your excavator that you know is not painful, and if the patient flinches you know that he, or she, is wilfully trying to deceive you and to take more care than is necessary for fear that you may hurt unnecessarily. If you do discover such a condition you must be very firm and inform the patient of what you have found. Then display firmness and get on with the work.

Now another small point whilst treating a patient is never unnecessarily to touch the patient's face. It is quite easy, if you take care, not to maul a patient's face with your fingers, and the easiest way to do it is to have a napkin between the fingers and the face, and in that way prevent the rest of the hand, which may be hot and clammy, from touching the patient's face. You do come across a number of hyper-sensitive people that object to having your hands mauling their faces.

With regard to children, they are perhaps as trying as most, but with tact and consideration it is perfectly astounding what can be done with them. Children that come to you extremely apprehensive can with care be brought round to be very sensible little patients upon whom you can operate a great deal. It is perhaps one of the greatest delights of dentistry treating children in that way. As a broad principle with children, once you have got their trust, never under any circumstances abuse it; it is unfair to the child, and you will for ever after lose that trust and be unable to carry on the work as you would like. In order to gain the trust of the child there should be no concealment of instruments, and never attempt to deceive them. Everything should be perfectly open and above board, and the child should be told exactly what is going to be done. Some may think, and do think, I know, that this is wrong, but I am absolutely convinced in my own mind that it is the correct treatment, and that after a considerable number of years of treating children. In the commencement of the treatment of children, especially with nervous ones, very short sittings should be attempted only, otherwise their nervous systems may be played upon to such an extent that you may wear them out very easily. It is very easy with short sittings if you have once gained their trust. You can generally amuse children quite easily in the chair by referring to your various instruments by pet names and such like, which appeals to the child considerably and helps you to get on with your work.

To come back to the general treatment of patients, with regard to your instruments, all of them should be kept extremely sharp, and every movement of an instrument should have a definite purpose. One has often seen in the Conservation Room students using excavators so blunt that you could never hope to cut a piece of dentine at all, but you could possibly scrape a little piece of dentine away here and there. Sometimes, too, the burrs are so blunt that they will not cut, and can only heat up and cause pain. Therefore the question of sharp instruments applies just as much to burrs as to excavators. Excavators should be continually sharpened, and it is well worth the time and trouble spent upon it. With such excavators you can clear out a cavity readily and with much less pain to the patient than

scraping with a blunt one. I have often seen students scraping away, I might say like a hen scratching for its food, at any rate giving unnecessary pain and trouble to the patient, and not doing any effective work. Burrs that are sharp will pain a patient very much less than blunt ones, and of course do the work much more efficiently; they will not heat up and so give the patient a thermal shock in addition. Speaking of thermal shock, all instruments should be warm before putting into a patient's tooth. It frequently happens that an excavator is put cold into a big cavity and the temperature of the excavator itself causes pain quite apart from the cutting or scraping. Also when syringing out a cavity or rinsing out the mouth, the patient should always be provided with water of the exact temperature. In syringing out a cavity remember that if you take water at the temperature of the mouth, in a glass and suck some into a syringe and squirt into a tooth, it is much cooler by the time it reaches the tooth, therefore the water in the glass should be several degrees higher than the temperature of the mouth. With a little practice you soon judge the temperature with your finger. The ability to judge to a nicety the temperature required is a point which should be studied very carefully by you all. The temperature may be too high and that will cause as much pain as if too cold.

With regard to giving an anæsthetic, I will say a few words about that in conclusion. When a patient comes to you for an anæsthetic that patient is generally at the worst or the lowest ebb of his nervous stability, other things being normal. Those of you who have had an anæsthetic must have realised it is an uncomfortable moment just when you are about to be made unconscious. The most hard-headed person or the person with the strongest nervous constitution is bound to have a slight feeling of discomfort when he is about to be made unconscious with an anæsthetic. Now imagine a particularly nervous patient, and you can guess somewhat what her feelings are likely to be. They are, in a large number of cases, I am convinced, very uncomfortable feelings indeed in fact, I would go so far as to say that in all patients that take an anæsthetic for the first time, some 50 per cent. of them have a feeling at the back of their minds that they are not going to wake up again. Therefore, you can quite imagine that a large number of patients that come for an ordinary gas administration are so sensitive about it that they are somewhat unstrung, and you have to talk to them and persuade them in very gentle terms, and not only that, but you have to treat them with gentle fingers. I have often seen in the gas room a dresser putting in the mouth prop, not only in a most uncomfortable way, but in a most slap-dash and rough manner. Now you can imagine the feelings of the patient that happens to be a nervous one when he or she is roughly handled merely in the preliminary stages of having an anæsthetic. It is of the utmost importance, therefore, that the patient should be treated gently, and the prop put in very gently and in a comfortable position. It is always uncomfortable to have a prop in the mouth. Never under any circumstances call that prop a gag. The patient does not like the term gag, but if you call it a prop merely to keep the teeth apart the patient is reassured. Another slight instruction in the insertion of this prop; when you have put it in do not tell the patient to bite because it is the very thing that he cannot do and that is the object with which you put it in. If you do tell the patient to bite and he tries to, at once he is upset and you are making the conditions worse for the anæsthetic. Therefore merely tell the patient that the prop is put in to keep the teeth apart and ask him to hold it there with the teeth. That I think completes all the points that I was going to offer to you with regard to consideration for your patients. Remember that there are other things to think about and work upon more than simply turning out a magnificent piece of work: that the whole of your work must be tempered with justice and consideration for the patient. It is sometimes difficult to steer a clear course between your duty and the patient's feelings. But that must always be your main object in all your work.

Papers by Guy's Men.

Alan H. Todd, M.S., B.Sc., F.R.C.S. Case of Chronic Arthritis of the Knee in a Syphilitic Boy.—Proc. Royal Soc. Medicine, Orthop. Sub-Sect., Aug., 1921.

—— Fractures of the Carpal Scaphoid.—*British Journal of Surgery*, No. 33, July, 1921.

Publications Received.

Hospital, Hospital Gazette, Nursing Times, Abstracts of Bacteriology, The Prescriber, Medical Science, New York State Journal of Medicine, Zacchia, Ivory Cross Journal, St. Bartholomew's Hospital Journal, St. Mary's Hospital Gazette, The Serpent, Fight Against Disease, Indian Medical Record, Lewis' List of New Books, Charing Cross Hospital Gazette, New Zealand Journal of Health and of Hospitals.

Annual Prize-Giving.

The Annual Distribution of Prizes was held in the Physiological Theatre at 3 p.m., on Monday, July 18th. Our Treasurer, Viscount Goschen, presented the prizes. This gathering, as last year, was a purely private affair, and only Guy's men were present.

The Dean, Professor Johnston, read out the names of those who won prizes, and each man as his name was called came up to receive his medal or certificate, and shook hands with the Treasurer.

At the conclusion of the presentation Lord Goschen rose and congratulated the prize-winners, offering his condolences to those who had not succeeded. He said that he considered the divorce of the prize-giving from the Annual Garden Party a desirable proceeding, and was glad to see that we had followed the precedent established last year. He would not make a long speech, but would follow the example of a clergyman who recently cancelled his sermon owing to the heat—the parishioners thought this one of their pastor's most sensible decisions. But he felt that as he was addressing a number of Guy's men who were perhaps about to leave Guy's, or at least were about to enter upon a new sphere of work, he should remind them that this was a very interesting period in the history of medicine. Public interest was being awakened, as it had never been before, in the problems that were constantly before our profession, and it was up to us to keep up, as far as possible, this interest on the part of the laity. The duties of medical men were becoming more and more extended, and now we had not only to cure diseases, but must add to this the duty, almost more important, of prevention. Every man must do his bit, however humble, and all Guy's men should adhere to this spirit, upon which so much depended. We must realise that team-work is the essence of success, and each man should play his part in the team. In conclusion, the Treasurer reminded us that wherever a Guy's man was, the spirit of Guy's should help him. The doings of Guy's men were always followed with the greatest interest by their Alma Mater.

Dr. Fawcett, as the Senior Physician, replied to Lord Goschen's Speech, and showed us how much the spirit that had grown up in Guy's had been due to our Treasurers. By a sad irony of fate Thomas Guy had died ten days before his hospital was opened, and there was no doubt whatever that the Treasurers of Guy's had done individually more than any other group of men in carrying out Guy's wishes and evolving our great traditions. The Treasurer was, indeed, our lord and master, the head of the Medical School, and we were ever grateful to Lord Goschen for continuing the precepts transmitted to him through his twelve predecessors. The present time was a very anxious one owing to financial stress. No one realised this better than our Treasurer, and, as Mr. Cosmo Bonsor, twenty-five years ago, and for many a year after, did much great work for us, so now Lord Goschen was on the offensive. We, the Staff and Students, must pull our weight in the boat—the Staff in the privileged position of advisers to the Treasurer and Governors, the students as the Treasurer's supporters and trusted agents. In so doing we could show our gratitude to the Treasurer for all the work he had done. Sir Samuel Wilks had said that institutions, as well as men, owed a great deal to heredity. Guy's had a goodly heritage, and, in the future, our love for our Hospital might occupy a larger share in our being than even our school or university, and we should remember that in that great foundation the Treasurer was the chief of the clan. "King" Harrison had been a moving spirit in the foundation of our Hospital, and the epithet of "King" applied to him showed how complete was the authority which our Treasurers had held. The speaker said he often imagined Thomas Guy looking down upon us and wondering what a large and busy hive had grown out of the smaller one he started. We had, perhaps, some drones, but the Dean and Treasurer managed to get rid of them in time. If Guy were looking at us now, we could be sure he was saying, "Well done, my sons of Guy's, you do well to honour my Treasurer." Dr. Fawcett concluded by moving a cordial vote of thanks to the Treasurer for distributing the prizes.

Sir Alfred Fripp, as the Senior Surgeon, seconded Dr. Fawcett's motion. He said that it was his function at this gathering to say "Aye, aye," to the Senior Physician's remarks, and reminded us that Dr. Fawcett was not only the Senior Physician, but also the Senior Fellow of the Royal College of Surgeons present. He, like the Treasurer, offered his congratulations to the successful prize-winners. To those who had not won anything—he supposed the two empty rows of seats behind the successful candidates represented them—he would point out that examinations are not everything. He quoted the instance of one candidate, who, after failing at the Primary Fellowship in a certain subject, obtained honours in the same subject at another different examination a month later. Another little example he remembered—he would mention no names—was that of a man whose muscular development was responsible for getting him through. This person had made one ridiculous answer, and the examiner, laying a protesting hand upon his arm, was struck with the magnificent development of his biceps, and asked him how he did it. As the examiner had been a keen athlete, the candidate was asked no more questions about his examination subject, and the *viva voce* had become

a discussion on physical culture, when the bell rang. Sir Alfred said he had the greatest pleasure in endorsing Dr. Fawcett's remarks about our Treasurer. No man was doing more for our Hospital than Lord Goschen, who was always ready to help us. He concluded by seconding most heartily Dr. Fawcett's motion of a vote of thanks to the Treasurer for distributing the prizes and for his interesting remarks to us.

Lord Goschen thanked us for the reception given to the motion of a vote of thanks, and, as the meeting broke up, the President of the Residents led three cheers for the Treasurer, which were given in the best Guy's manner.

MEDALLISTS AND PRIZEMEN.

Open Scholarships in Arts.—Kenric Charles Billingham, Brighton Grammar School, War Memorial Scholarship of the value of £45 per annum for 5 years. Edward Ian Ransford Marsden, Cheltenham College, £100.

Open Scholarships in Science.—Reginald Albert Nash, Preliminary Science Class, Guy's Hospital, £120. Alfred Beresford Plant, Preliminary Science Class, Guy's Hospital, £50.

Scholarship for University Students.—Harold Charles Beccle, University College, £80. Nils Lövold Eckhoff, University of Cape Town, £75. George Thompson Henderson, B.A., Gonville and Caius College, Cambridge, £35.

Open Scholarships in Dental Prosthetics.—October, 1920, James Alfred Hudson, John Barnatt Roberts, equal, £15 each.

Scholarships in Dental Prosthetics for Students of Guy's Hospital.—October, 1920, Harold Slater, £30. May, 1921, James Russell Atkinson Moore, £30.

Junior Proficiency Prizes.—Leslie George Housden, £20. Thomas Stephenson Blacklidge, George Frederick Gibberd, equal, £12 10s. each. Eric John Greenwood. Certificate.

The Beaney Prize for Pathology.—Arthur Henry Douthwaite, £34.

The Michael Harris Prize for Anatomy.—Jehiel Jonas Lewinstein, £10. James Jemson, Certificate.

The Wooldridge Memorial Prize for Physiology.—George Frederick Gibberd, £10. Eric John Greenwood, Certificate.

The Hilton Prize for Dissections.—Douglas William Claridge Northfield, John Wenzl Schollum, Harold John Selby, equal, £2 each.

Dental Prizes.—Fourth Year's Prize in Dental Subjects, Martin Braun, £10. Fourth Year's Prize in General Subjects, Powis Naranzo Cornwallis Conway-Jones, £10.

Prize for Operative Dental Surgery.—Dudley Anthony Parsons, £10. Herbert Frank Miles, Certificate. Harold Greaves, Certificate.

Newland-Pedley Gold Medal for Operative Dental Surgery.—Harold Greaves.

Golding-Bird Gold Medal and Scholarship in Bacteriology.—Edward Horace Richards, £20. Alfred Talbot Rogers, Certificate.

Treasurer's Gold Medal for Clinical Medicine.—Montague Maizels.

Treasurer's Gold Medal for Clinical Surgery.—Joseph Philippe Couacaud.

Correspondence.

To the Editor of Guy's Hospital Gazette.

The late Dr. A. S. Taylor.

Dear Sir,—There is a fact in connection with the late Dr. A. S. Taylor which I have been waiting to hear mentioned by someone who knew him more intimately than I did, and that is if my memory is not at fault, that his wife was a Guy's woman—Miss Cole, Sister Lazarus—a charming lady to whom, if she survives him, I offer my belated condolences. For although I only knew him through being in residence with him, still such acquaintance, though short, is pretty thorough. And the announcement of his death made me think that I really must attend the next Biennial Dinner, for the years go by rapidly and take away first one, and then another of one's old friends, and fill one with unavailing regret.

Yours truly,
FRANCIS HEATHERLEY.

Ashville, Audenshaw,
Manchester,
27th July, 1921.

Dear Sir,—Would it not be possible to do something to induce more dressers to be present at the acute surgical "take-in" work? At present it seems to be customary for only the two "take-in" dressers to live at the Hospital during their firm's "take-in." With surgical firms at their present strength that means that experience of acute surgical work is practically limited to one week during a student's whole career. Surely this is hardly enough to enable him to deal with any confidence with the urgent surgical cases, which he will meet with in after life. I believe that before the war it was usual for the whole firm to live up during the firm's "take-in" week, thereby enabling not only the "take-in" dressers, but also the rest of the firm, even including the ward clerks, to get some prac-

tical experience at any rate in the diagnosis of acute abdominal conditions. The greater part of the acute work is done at night and the main difficulty is not so much that the dressers are unwilling to live up, as that it is difficult to find accommodation. It is true that at present the College is full, but could not some arrangement be made whereby full surgeons' dressers are given a priority claim in obtaining rooms in College. At present a considerable proportion of the rooms in College are occupied by junior students. It is hard to believe that the latter gain much in health or even in morals by occupying rooms that would be much better given to those, whose work needs their more or less constant attendance at the Hospital.

Further is it not time that some official arrangements were made for providing sleeping accommodation for the "take-in" ward clerks. Recently they have been sometimes sleeping in the dresser's room or even in the wards owing to lack of accommodation elsewhere. Seeing that no porters are provided for taking cases up to the wards at night, surely the ward clerks on whom this duty devolves should be provided with quarters if not with board.—I am, Sir, yours, etc.,

REGISTRAR.

Guy's Hospital,
London S.E.1.
August 2nd, 1921.

Reviews.

The Clinical Examination of Diseases of the Lungs. By E. M. Brockbank, M.D.Vict., F.R.C.P., and A. Ramsbottom, M.D.Vict., F.R.C.P. (Messrs. H. K. Lewis & Co., Ltd.) First Edition. Price 4s. 6d.

This little work aims at teaching the physical signs of lung diseases. It cannot supersede the teaching of Registrars and Physicians, but is useful in helping to understand their words. With the help of this little book the perplexed student may at his leisure, after a round, examine a patient and study in detail the characters of the physical signs which have been pointed out to him as typical. The work deals in turn with what may be found by inspection, palpation, percussion and auscultation, and finishes up with a brief resumé of the physical signs of the common lung diseases.

Regional Anatomy. By T. B. Johnston, M.B., Ch.B. (Students' Synopsis Series.) (Messrs. J. and A. Churchill. 1921.) First Edition. Price 12s. 6d.

This volume is perhaps the most successful one yet published in this useful series of synopsis. Certainly to us here at Guy's it is the most interesting and the most welcome, for we have learnt to value Professor Johnston's teaching of anatomy and we are glad to have such a concise manual on this subject.

The book, as its title suggests, deals with anatomy region by region, and one is not confused as one is in most anatomical synopses by having to look up bones in one chapter, muscles in another, joints in a third, and so on. The book should be very useful for students revising their "parts" after dissection or before examination. With the idea that it will be used with anatomical specimens Prof. Johnston has included very few illustrations. Those that do appear are simple diagrams which explain the position of the cerebral nuclei, and the course of the various nervous tracts, a subject which cannot be understood without diagrams.

By the use of different kinds of type, attention is called to the things in anatomy which are really important to the student in his later clinical career. The text is extraordinarily lucid, and at Guy's at least the book should have a great vogue.

Studies on the Bacteriology of the Alimentary Tract. By N. Mutch, M.A., M.D., F.R.C.P., and Jane Mutch, B.A.

This paper gives some of the results of investigations upon the ætiology of chronic disease of the alimentary tract: the streptococci form the chief theme of discussion.

The first part traces the history and distribution of the streptococci throughout the intestinal canal. The authors have devised the glycophilic (or acceleration of growth of streptococci in dextrose) property of streptococci as a means for differentiating the alimentary from other groups.

They have shown how favourable to intestinal infection is achlorhydria and in one case where a patient before laparotomy had an attack of tonsillitis, recovered the same organism from tonsil and duodenal contents, the duodenal contents ordinarily giving no growth. Another important result of these investigations is where it is shown that streptococci may flourish in the ileum in great quantity while cultivations of the fæces remain free from them, owing to the greater tenacity of the bacillus coli in the large bowel. The effects of ileal and local stasis in the small intestine in producing large growths of cocci and subsequent infection of the intestines are also insisted upon.

Diathermy: Its Production and Uses in Medicine and Surgery. By Elkin B. Cumberbatch. (Messrs. William Heinemann, Ltd.) Price 21s. nett.

It is not improbable that another century may find electro-therapy supreme, in spite of the pre-

mature optimism of some of its exponents. In the meantime certain of its measures suggest a sledge hammer policy representing somewhat uninspiring attempts to dislodge disease by the exhibition of brute force. Nevertheless, a sledge hammer may be useful on occasion, and the afflicted are apt to overlook a lack of artistry or strictly scientific method in their cure. Provided we regard diathermy as an occasionally successful weapon rather than a phenomenal advance in scientific treatment, it is well worth our while to study the details of its application.

The production of high frequency currents demands a grasp of electrical technique beyond the attainments of the average medical man. Surgically speaking, the mode of action is simple enough, and merely requires a special acquaintance with the part under treatment. "Medical" diathermy must be in the main empirical, as the physiological effects of comparatively localised thermal changes need further study.

The book under consideration gives a very good outline of our present day knowledge of the subject. But it is difficult to recommend to any particular class of reader. Few individuals are likely to possess an intimate understanding of the surgery of the throat and of electrical condensers, for instance. Assuming that team work is inevitable, on the other hand, each performer will require more information in his own branch than he can find in a brief survey of this type. However, the book is easily read, though perhaps a trifle expensive.

Abstracts of Current Medical Literature.

Lumleian Lectures on Some Points in the Aetiology of of Skin Diseases. (*Lancet*, July 23rd.)

Arthur Whitfield considers focal infection in relation to skin diseases drawing special attention to oral sepsis and tonsillar infections. He considers the difficult subject of the influence of the nervous system and comes to the conclusion that certain cases—few in number—are undoubtedly due to psychic influence, while others can usually be traced to some organic cause. Reflex irritation is an occasional factor.

Case of Chronic Arthritis in the Knee in a Syphilitic Boy. (Proc. Roy. Soc. Med., August, 1921.)

A. H. Todd discusses a case of chronic arthritis in a patient with a strong positive Wasserman and suggests that the examination of all cases of chronic arthritis should include the Wasserman test as a routine examination.

A New General Anæsthetic. (*Ibid.*)

R. L. Mackenzie Wallis and C. Langton Hewer report observations on the use of a new anæsthetic sold under the name of "Ethanesal." Four methods of administration are described and an analysis of results given.

Discussion on the Causes, Prognosis and Treatment of Sterility. (*Ibid.*)

A. E. Giles considers the prevalence of sterility and draws attention to the responsibility of the male partner. The use of contraceptive agents is strongly deprecated.

Sterility in the Male. (*Lancet*, July 30th, 1921.)

Kenneth Walker discusses methods of investigation of Sterility of the Male. A thorough examination of semen is always necessary. In Azoospermia a complete clinical examination of the accessory vesical glands and the urethra, by including posterior urethroscopy, will almost always reveal evidence of disease.

Methods of treatment and the role of endocrine glands are discussed.

Extrusion of Renal Calculus. (*Ibid.*)

H. T. Orr-Ewing reports a case of extrusion of a renal calculus in the loin of an Arab woman, in which the events were practically symptomless.

Aero-Urethroscope. (*Lancet*, July 23rd, 1921.)

Wyndham Powell has considerably improved his Aero-Urethroscope; details of new operative urethral canulæ are given. By means of a separate cylindrical sheath embedded in the wall of the canula, various instruments can be projected and used within the urethra. This excellent instrument affords an uninterrupted field of vision, perfect control of the various instruments, and is evry simple in design.

Local Anæsthesia for Extensive Abdominal operations. (*Amer. Journ. Surg.*, July, 1921.)

H. Finisterer, of Vienna, has performed 1,500 laparotomies under local anæsthesia, and now does nearly all operations for appendicitis, using the

same anæsthesia. Fatal lung complications are almost entirely avoided, and in such urgent operations as those for intestinal obstruction or peritonitis, the author claims that an exact conducting anæthesia of the abdominal walls combined with a short ether narcosis is the best, as the blood pressure is not diminished thereby. Local anæthesia must be perfect. The author claims that this can be achieved.

Wassermann Test in Malaria. (*Journ. of Hygiene*, 1921, 19, 277.)

Hekewerth and Kop carried out tests on three Europeans and 41 Natives (in Java) who were affected with malaria. A description of the tests and their technique is followed by an account of results obtained. Two complete tests were carried out, one with heated (56° C.) and the other with unheated serum.

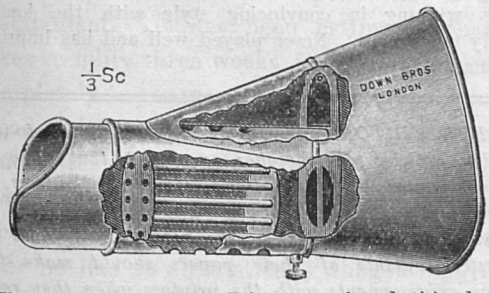
With unheated serum a majority gave a positive Wassermann Reaction which might persist from 3 to 6 months, but usually yielded to quinine treatment.

Specialities.

A Compact Warm Ether Inhaler.

This Inhaler has been designed to secure some of the advantages of Warm Ether Anæsthesia, and at the same time, being independent of an extraneous source of heat and not needing continuous pumping of air, to be sufficiently compact to be easily accommodated in the anæsthetist's bag.

A fairly obvious device is the utilisation of the heat otherwise lost to the patient in his expired breath; this takes place in all closed forms of inhaler and to a certain degree with open methods under a mask. It is, incidentally, exactly comparable to the exhaust heating of a motor car carburetter.



The inhaler in which I have employed this device somewhat resembles the small Roth-Dræger instrument and consists of three parts: (1) a face-piece carrying the usual rubber cushion and provided with inspiratory and expiratory valves; (2) a radiating chamber containing nineteen thin metal tubes; and (3) a container for sponge or gauze upon which the ether is dropped. Ether is inspired from the container through the warmed "radiator" tubes, while the expired breath is directed by the expiratory valve through a short passage into the radiating chamber where it passes between the tubes, to which it gives some of its heat, and escapes through holes in the opposite side. The radiator is locked to the face-piece by a small screw, and the container can be revolved into any position convenient for the dropping of ether. The inhaler is strictly of the semi-open type, but the airway has been kept everywhere as free as possible to prevent restriction of breathing and promote interchange of heat. A slight amount of re-breathing is allowed by the volume of the face-piece, the in- and out-going streams being kept otherwise separate.

Without the radiating chamber in use the temperature of the inspired vapour above the face-piece is from 32° to 38° F. This is considerably lower than that shown by a thermometer under a Skinner's mask during "open" administration, but here the actual temperature is variable and uncertain owing to the fluctuation of the alternate warm and cold streams. On bringing the radiating chamber into use the temperature of the inspired vapour rises in the course of a few minutes to 65°—70° F., occasionally higher, generally rather above room temperature, and remains fairly steady. This is again lower than can be obtained with an extraneous source of heat, but is, I think, sufficiently high for the purpose.

There is a considerable economy of ether shown over the use of a mask, and a welcome diminution in the amount of ether in the air surrounding operator and anæsthetist. Anæsthetic mixtures can be used equally well if desired.

The instrument is made entirely of metal except for the rubber cushion and the valve-flaps, which are easily renewable; it can, therefore, be readily sterilised. Its length is approximately 7in. and its weight 13oz. It has been made for me by Messrs. Down Bros., to whom I am also indebted for the illustration.

I have not been able to find any description of an inhaler on these lines; if such exists I must apologise to the designer for my unconscious plagiarism.

G. A. TICEHURST.

Notice.

We are asked to announce the fact that there are appointments vacant for three Assistant House Surgeons and one Ophthalmic House Surgeon. Applications should be addressed to the Treasurer at the Superintendent's Office, Guy's Hospital, S.E. 1.

Nurses' Lawn Tennis.

At Honor Oak Park on Friday, 22nd July, Guy's met the St. Bartholomew's team, who proved to be the most formidable opponents that we have so far had to tackle. We beat them by the very narrow margin of three games, the result being in the balance right to the end.

In the "A" match, although Bart.'s won the first set 6—1, the play was very even, deuce being called in nearly every game. The second set went to us with the score of 6—3, but in the last set Bart.'s were again in the ascendant and the match went to them 6—1, 3—6, 6—1. The Guy's team played a plucky game, and though beaten by a better pair, should not have lost by so large a margin. Had Nurse Stubb's injured foot not been troubling her so much we might have fought a closer game.

The "B" team (Nurse Vian and Nurse White) was thus faced with a formidable task. They had not only to win their match, but they had to win it convincingly, for they had a deficit of 7 games to recover. They began well, winning the first set by 6—1, and so reducing Bart.'s lead by 5 games. In the second act we went ahead again and led 5—1. It seemed that the match was all over bar shouting, but all at once the Bart.'s pair began to rally, and, winning four consecutive games, they brought the score to 5 all. Then each team lost a service game, and it was 6—6. Guy's led at 7—6, and then Nurse White won her service game and so the set. Thus, each Hospital had won two matches and each had won 22 games, so that the decision rested upon who should win the final set. The result of this set was not long in doubt, for the Guy's pair now out-played their opponents and won the set 6—3. Guy's thus scored 28 games to Bart.'s 25, and so passed into the semi-final.

Guy's have already played and won the semi-final tie against St. Marylebone Infirmary. A report of this will appear in our next issue. We wish the Guy's team the best success in their final match against London Hospital, the holders of the Cup.

Lawn Tennis.

The Final of the Inter-Hospital Lawn Tennis was played against Bart.'s at Perivale on July 31st. The courts were in fairly good condition, but there was a strong wind blowing, which made accurate placing very difficult.

In the Singles—M. Jackson played R. Roupell, but the latter proved far too good, and ran out the winner with the loss of only one game, 6—1, 6—0.

A. Daneel versus D. Brown.—The latter had a fine service and volleyed well, and won in straight sets 6—1, 6—2.

E. Neser versus R. Johnstone.—Never found his opponent too steady, and lost 6—3, 6—1.

L. Nurick had a gruelling game with R. Powell, and after a close fight managed to win 6—3, 8—6.

J. S. Jacobsz struck exceptionally good form, his length and placing being of a very high order. He won 8—6, 6—0.

B. Keyter was in a class above his opponent, and won 6—2, 6—2.

After dinner the Doubles took place :—

Jackson and Daneel beat Brown and Powell 9—7, 6—4. Beat Cody and Smuts 6—1, 6—3.

Nurick and Jacobsz beat Roupell and Johnstone, 6—2, 8—6. Beat Brown and Powell 6—3, 6—4.

Keyter and Neser beat Cody and Smuts 6—2, 4—6, 6—3. Versus Rupell and Johnstone 6—2, 6—8 (unfinished).

The Guy's Team were much better than their opponents in doubles, the combination being very good. They rose to the occasion, and all gave of their best.

The Tennis Club is to be congratulated on their fine effort in bringing back two Cups to the Hospital. Both Teams are to be commended for their keenness and co-operation throughout the season.

Final of the Lane-Washbourn Cup.

The Final was played on Wednesday, 27th July. M. Jackson, the holder, and E. Neser, who qualified by defeating no less redoubtable opponents than J. Jacobsz and L. Nurick, the latter in straight sets. Neser lost the first game, won the second, but Jackson pulled ahead to 4—2. Neser, however, improved, being frequently applauded for fine strokes, and drew level to four games all. After a hard fight Jackson, by keeping a splendid length, won the first set 6—4. Jackson was on top all the time during the second set, winning in convincing style with the loss of only two games. Neser played well and has improved remarkably of late.

THE EDITOR will, at all times, be glad to consider articles or sketches, provided that they are accompanied by the writer's name and address, not necessarily for publication. The payment that the GAZETTE *can offer is merely nominal. Authors who desire reprints of their papers should make their own arrangements with the printers when they return their proofs. All contributions to be addressed to the Editor, "Guy's Hospital Gazette," Guy's Hospital, London, S.E.*

ED.—A. T. R.

GUY'S HOSPITAL GAZETTE.

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Passim.

THE practice of allowing students, even of encouraging them, to give blood for transfusion is far too prevalent in the Hospital. A patient is admitted in a very collapsed condition and blood transfusion is decided on. Even if any of his relatives are available, there is no time to test their blood groupings. So the house-surgeon goes off to the College to find a Group IV. donor. It speaks well of the men that he rarely has difficulty in finding a willing donor. For although the day is past (or passing) when anyone who gave a pint of blood became automatically a hero with his photograph in all the illustrated papers, yet the giving of this amount of blood does certainly lay some strain upon the donor's metabolism. It has been estimated that it takes roughly three weeks for the normal man completely to recover from the loss of a pint of blood. [This was recognised by the army authorities during the war, who gave three weeks or a month's sick leave to donors of blood for transfusion.] So that for three weeks after he has so altruistically obliged his friend the house-surgeon, the donor's activities remain below par and the efficiency of his unit, and indirectly, of the Hospital, is lessened. If for these reasons alone, we think the practice ought to be discouraged, or even prohibited.

It would not be difficult to follow the American plan of having professional donors. Transfusion is not often done here more than once in a week, so that to ensure that each should not be called upon to give blood too often, we should only need about four donors. They should live at, or very near, the Hospital, so as to be available at the shortest notice. There is no reason why they should not be given some light work to do about the Hospital, which could be easily discontinued, say, for the week following that in which they gave blood. They would, of course, be subjected to stringent blood tests before being engaged, and their blood grouping (preferably IV.) should be known.

Such a system has been in use for years now at most of the large American hospitals, and there is no apparent reason why it should not be adopted here.

ON another page we print an account of the transactions of the Pupils' Physical Society for the Session 1921-22. This society is gradually regaining its pre-war popularity. It was noticeable however, throughout the last session that the attendances were made up time and again

by the same few men. Only a very small fraction of the men in the wards attended and most of them had already spent upwards of a year in clinical study. If only the men who had just entered the wards had realised how valuable these meetings can be, especially the clinical ones where puzzling cases are shown and informally discussed, we feel sure they would have attended in far greater numbers.

The Hon. Secretaries offer us a very interesting programme for the coming session. It is especially interesting to see that two meetings have been arranged in conjunction with St. Thomas's Hospital. The Physical Society was of course founded when Guy's and Thomas's were neighbours in the Borough, and when the union between them was broken, each Hospital carried on its society. Now, after nearly a hundred years, the two societies have arranged to meet together again for two meetings during each year. At these meetings clinical cases and pathological specimens will be shown and discussed. The first meeting will be held at St Thomas's on December 8th. We feel sure that there will be a large gathering of Guy's men at Thomas's on that day eager to display their clinical acumen.

The Guy's Rugby XV. by the excellence of their play during the past two seasons have earned the right to be regarded as one of the leading teams of the country. The fixture list for the next season, which we will publish in our next number, shows that such first class teams as Cardiff, Gloucester, Blackheath and Universities have come to realise that Guy's have more than regained their pre-war standard and are a side well worth meeting. For we have a far higher percentage of really first class fixtures this season than we have had for many years. We are gratified too to note that quite half of these good matches will be played at Honor Oak, for often in previous years we have met the best teams on their grounds, but have not been able to arrange return matches in London.

We think that in view of the larger attendances which these good matches are certain to draw, some better arrangements should be made at Honor Oak Park than those which existed last year. Then, in order to obtain a good view of a good match, one had to be at the ground at least three-quarters of an hour before the advertised time of the start. If one delayed one's arrival until a quarter of an hour before the beginning, one saw practically nothing whatever of the game.

This year, of course, the stand has been enlarged, so that it will now hold nearly a thousand people, but there is still no adequate accommodation for those who have not been able to secure stand tickets. May we suggest a scheme, which we believe would be quite feasible, and which would involve no very great expense.

On the side of the ground opposite the stand it has been the practice for years now to place a row of duck-boards. It is very noticeable to people standing on these boards how valuable are the few extra inches which they give. Standing on the boards one can see quite easily over the heads of the people standing on the turf just in front. Some late-comers last year used to stand on two duck-boards placed one on top of another and so get a better view of the game. Could not this scheme be extended and officially recognised next year. We could have in front a single row of rope seats, then behind this, say, four tiers of duckboards, in the first tier, one board; in the second, two; in the third, three; and in the last, say, five boards. This improvised stand would have many advantages. It could be easily removed in the summer and replaced in the winter, and would do no appreciable harm to the cricket

pitch. It would not be expensive, for it involves only the purchase or the manufacture of about five hundred duck-boards. The cost of these we feel sure, would be amply covered by the increased number of spectators we would be able to attract. For Guy's ground is admirably situated; it is easily accessible to people from a very wide district; our only competitors for the Rugby enthusiasts of South London are Blackheath, the London Welsh, and Catford Bridge. With our present programme we ought easily to be able to draw ten thousand spectators to each of our home matches if we only took the trouble to make adequate arrangements for them.

A short while ago we were pleased to be able to record and commend the plan which had been introduced of inviting practitioners to visit Guy s and talk to men about to enter practice. Two such visits have already been made and have proved very successful. During next week Dr. J. E. McDougall, who was a general practitioner before he specialised in otology, will visit the Hospital and will talk on some of Mr. Layton's cases in Ruth and Barnabas. A notice will be posted to state the date, which will be either Wednesday or Friday, at 11 a.m.

We have received from Dr. W. A. Phillipps a very interesting book on the history of small-pox, written in 1815, by Dr. James Moore, who was a brother of Sir John Moore, the great soldier.

In view of the recrudescence of small-pox in the Midlands, this book, which traces the occurrence of small-pox back to the earliest times and tells of ages when it was almost universal makes very interesting reading. The book is dedicated to Edward Jenner, the pioneer of vaccination, to whose epoch-making discovery we owe our freedom from small-pox to-day.

The fortnightly abstracts of current medical literature, which we began to publish some months ago at the request of one of our readers, have not fulfilled all our expectations. We do not think that they are sufficiently valuable to justify their occupation of a page in each Gazette, so we propose to abandon them.

The third number of the new series of the Reports has now appeared, and is reviewed in this Gazette.

Just as we were about to go to press, we heard the tragic news of the death of Dr. H. E. Cuff, and his two daughters. Dr. Cuff and his family were spending their holiday on the Norfolk coast. On Monday last, whilst bathing, Dr. Cuff's two young daughters got into difficulties, Dr. Cuff went to their rescue, but all three got involved in a current and were drowned. The tragedy was all the more pathetic in that Mrs. Cuff was present and was a helpless witness of the fatality.

Less than a month ago we published a letter from Dr. Cuff, in which he wrote of his late friend Dr. A. S. Taylor. Now Death has stretched forth his hand and has taken him too. We sincerely offer our deepest sympathy to Mrs. Cuff in her great sorrow.

Change of Address.

F. W. Crook, M.R.C.S., L.R.C.P., 11, Torrington Square, W.C. 1.

C. S. Lane Roberts, M.S., F.R.C.S., the Leeds Maternity Hospital, Hyde Terrace, Leeds, Yorks.

Appointment.

C. S. Lane Roberts, M.S., F.R.C.S., to be University Tutor in Obstetrics and Resident Medical Officer, the Maternity Hospital, Leeds, Yorks.

The War Memorial.

We have received the following description and critique of the War Memorial and the new Massage Building, which may prove interesting to those of our readers who may be architecturally minded It was written for us by Mr. Hope Bagenal, A.R.I.B.A., the Editor of the Architectural Association Journal, who recently visited the Hospital and inspected the new buildings.

GUY'S HOSPITAL WAR MEMORIAL.

The Memorial to Guy's Hospital men fallen in the War has been designed by Mr. Walford in the form of a monumental entrance gateway to "The Park" from the street known as Great Maze Pond. He has embodied in his design seven Tuscan columns taken from the Museum of the old Medical School. These columns being scarcely of a monumental height have been placed on pedestals, and carry an entablature of free design. The columns and entablature form an effect a screen linking the Monumental Arch with the buildings on each side. This use of old material has doubtless hampered the architect in his de ign. Four columns on one side are balanced by three and a pilaster on the other. It is to be regretted that the columns themselves are not of refined workmanship. The shortness of the columns and the inevitable width of their spacing gets something of an Early Renaissance or Jacobean effect. The cornice mouldings do not appear, owing to their design, to carry on the cornice line of the wall on the left hand side, although the height of that cornice line has evidently been taken as a determining feature of the design. The monumental archway which is placed not quite in the centre, owing no doubt to the existing pathway, consists of a fine masonry block pierced by an arch without imposts. Panels on either side of the arch are engraved, on the Hospital side, with the names of the fallen. Above the names appear the text "Their names liveth for evermore." In the same position on the opposite side of the arch is engraved "Erected by friends of the Guy's men who gave their lives in the Great War." The fine crest of Guy's Hospital with the motto "Dare quam accipere" occurs over each panel. The old railings, which at an early stage of the work were removed, might with advantage have been set back within the column openings, thereby giving a more unconfined aspect to the completed design when seen from outside. They have, however, been replaced on the old frontage line.

As a memorial it can be said to be an admirable and conspicuous record of names. The men, our friends and colleagues, fallen and already inevitably fading from the minds of the pre-occupied living, must be acknowledged to deserve a finer breath of inspiration than can be detected here. But the same may be said unhappily of the majority of memorials raised throughout the land. Here we have a noble list of names and an honourable gateway.

THE NEW MASSAGE BUILDINGS.

The new Massage Buildings are designed to provide accommodation for the latest treatment of patients by massage, baths, and electricity, and at the same time provide quarters for the training school where pupils can take the course for the certificates of the Chartered Society of Massage and Medical Gymnastics. In addition, the three upper floors are to provide extra amenities to the Nurses Home to which access is given by means of new doors into the existing nurses block.

It is to be regretted that the site selected inevitably involved the pulling down of an ancient and noted part of the Hospital buildings. Here stood, since the year 1797, the old Clinical Wards —John and Miriam—of which many Guy's men will always preserve an interested recollection associated with early Hospital duties. Now the old Clinical Wards have gone, and in their place stands a large classic facade in brick and stone, five stories in height and embellished by a composite Order somewhat heavy in treatment and surmounted by an elaborate screen pediment. The detail throughout is bold rather than beautiful, and a certain restlessness of effect is produced by the new demodé use of Ley-blocks over windows. The plan, however, shows a grasp of the various problems involved. It is roughly T-shaped and forms a self contained block. On the lower ground floor there are swimming and and whirlpool baths, and a large massage room, besides three class rooms and library for students, and store and laboratory accommodation. Two electric lifts capable of taking stretcher cases are provided. The ground floor, which has nine steps up from the ground level, provides a central waiting hall where patients assemble, also a large gymnasium and three treatment rooms. Owing to the steps stretcher cases have to be brought in by the subway to the lower ground floor. The gymnasium has a rubber floor presented by the Rubber Growers Association. The treatment rooms have floors made of Dicolite composition which is rounded in all corners and run up the walls to dado height. On the first floor the electrical treatment of patients will take place for which purpose electrical points are provided for all the necessary apparatus. The doors throughout the building are of oak with shallow panels, having rounded corners and exhibiting excellent joinery work. All radiators are hinged and will swing out from the walls. The new block which is undoubtedly an acquisition to the Hospital will cost, when fitted, £90,000 of which the sum of £23,304 in grants and donations has been received.

H. B.

Pupils' Physical Society.

The final meeting of the Session was held on Thursday, 11th inst. at 8 p.m. The attendances during the session showed that the keenness of the members is gradually regaining the pre war standard. There is still a lot of room for improvement, and it is hoped that the programme, which has been fixed for next Session and is printed below, will raise the enthusiasm of the ward students. It has proved rather difficult to get men to show cases and specimens, but it is hoped that in the future dressers and ward clerks having interesting cases will bring them forward on their own.

The combined Physical and Physiological meeting was a great success, and another fixture has been arranged with the medical and Physical Society of St. Thomas's Hospital, the first to be held at St. Thomas' and the second at Guy's; they will be combined Clinical and Pathological meetings. The list of officers is printed below. By the death of Sir George Savage the Society loses a very keen Hon. President who would have been present at certain of the meetings had not his health prevented him from travelling in the evening. Sir Charters J. Symonds was unanimously elected as Hon. President, and the Society is lucky in having another so keenly interested in its welfare.

The Treasurer's Prize of £5 was won by Mr. M. H. Mackeith. The Society's Prize of £10 for the best Paper read during the Session was won by Mr. M. E. Iban. Mr. Mackeith was also awarded the Society's Prize of £5 for the member who distinguished himself most in the discussions, and Mr. E. F. Wilson was awarded the £5 prize for showing the best Pathological specimen.

The subject for the Treasurer's Prize Essay for Session 1921–22 will be published later.

Officers:—Hon. President, Sir Charters J. Symonds.

Hon. Vice-Presidents, Sir William Hale White, Dr. Laurison Shaw, Sir Arbuthnot Lane, Dr. Fawcett.

Hon. Secretaries, Mr. W. H. Ogilvie, Dr. J. M. H. Campbell.

Presidents, Messrs. Shaw, Maizels, O'Meara, Douthwaite, Watson, Rogers, Hodgkinson, Couacoud, E. F. Wilson, Laver, Widgery, Doherty, T. Turner.

PROGRAMME FOR SESSION 1921–22.

1921.

Oct. 13.—Inaugural Meeting. Address by Sir A. Fripp.

Oct. 27.—Clinical Meeting.

Nov. 10.—Pathological Meeting.

Nov. 24.—Paper by Mr. Richards.

*Dec. 8.—Meeting with St. Thomas's Physical Society at St. Thomas's. Clinical and Pathological.

Dec. 15.—Combined Physical and Physiological Meeting.

1922.

Jan. 12.—Pathological Meeting.

*Jan. 26.—Meeting with St. Thomas's Physical Society at Guy's. Clinical and Pathological.

Feb. 9.—Paper by Mr. Widgery.

Feb. 23.—Clinical Meeting.

Mar. 9.—Paper by Mr. Rogers.

Mar. 23.—Treasurer's Prize Essay.

G. B. DOWLING,
J. GAYMER JONES,
Hon. Secs.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

Some Pulmonary Complications of Surgery.

DEAR SIR,—I have read with interest the report in your issue of 25th June of a clinical lecture by Dr. Ryle on the subject of "Pulmonary Complications of Surgery," and particularly with regard to cases of pulmonary embolus.

As a student I gathered the impression that pulmonary embolism was almost always fatal. To quote Dr. Ryle's own words, "The clinical form which the tragedy only too commonly takes is simply that a patient apparently convalescent is suddenly seized with urgent dyspnœa and distress, and dies in a few moments, or, even more dramatically, suddenly falls back dead in bed."

As R.M.O.B., however, I collected, out of some 700 cases, nine which I believe to have been instances of pulmonary embolism, of which only one was fatal. The fatal case was characterised by sudden acute pain, dyspnœa, and tachycardia, followed by death in about ten minutes, and it took place five days after a cholecystenterostomy for malignant pancreas. The other eight cases occurred after the following operation:—Gastrojejunostomy (one case), appendicectomy (two), appendicectomy and varicose veins (one), gangrenous appendix and general peritonitis (one), inguinal hernia (2), hysterectomy and salpingectomy (1).

The time of onset of lung symptoms after operation varied from five days in the fatal case to 39 days in the case of gangrenous appendix, which was complicated by femoral thrombosis. The average time was from 8–14 days in the other cases.

The symptoms noted were—sudden acute pain in the chest, dyspnœa, increase of pulse-rate, and usually a slight rise of temperature next day. The physical signs were those of a small patch of localised consolidation, but did not develop until some 24 to 41 hours after the acute onset. In every case the symptoms were relieved

by morphia or Dover's powder, with a local application of antiphlogistin. All but the one fatal case made perfect recoveries.

I considered at the time that these were cases of emboli in small vessels, and intended to make a note of them in the Gazette, but failed to do so. They are worth noting, because, as Dr. Ryle remarks, the text-books have so little to say on the subject, and emphasize the fatalities unduly, in my opinion.—I am, yours faithfully, GEOFFREY DUNDERDALE.

280, Loop Street,
Pietermaritzburg, Natal.
25th July, 1921.

Clinical Lectures.

Dear Sir,—I am stimulated by the fact that the hour for post-mortem examinations has recently been altered, following a suggestion which, I believe, first appeared in the Gazette, to draw attention to the fact that certain clinical lectures are delivered at times which are exceedingly inconvenient to many men for whom they are intended. It is the custom for the "Specialists" to give their lectures at 1.30 on Monday afternoons. I doubt if a more inappropriate moment in the whole week could have been selected, for at 2 p.m. on Mondays practically every Student holding a Ward Appointment is busy. By referring to the official time table I find that the following members of the Staff are occupying the attention of their respective firms. Out-patients: Messrs. Chapple, Ormond, Layton, and Trethowan. Ward rounds: Dr. Beddard, Dr. French, and Mr. Steward. Operating: Messrs. Bellingham Smith, Fason, Fagge, Rowlands. Davies-Colley, and Bromley. In addition, I believe, Dr. Fawcett goes round with his ward clerks on Mondays, and, of course, there are almost always several autopsies. There may also be other work going on of which I am not aware. At any rate I think I have made it sufficiently clear that the time chosen for these lectures makes attendance quite impossible for a large number of students.

The most suitable alternative now appears to me to be 12 noon. The wards at least are closed at this time and it would probably be arranged that out-patients should be finished in time for the firms engaged to get to the lecture, if there are objections to this time I hope that someone will point them out. It is true that compulsory systematic lectures have been dropped, but there is surely no reason why those remaining should be made inaccessible.—Yours, etc.,

MAURICE E. SHAW.

The College,
Guy's Hospital, S.E. 1.

The Biennial Dinner.

Dear Sir,—At the risk of being considered a bore I write to you again to remind your readers that Wednesday, October 26th has been fixed for the Biennial Dinner. The invitations are now being printed, and I hope that every Guy's man will receive his invitation not later than the end of the first week in September. Already quite a number of letters from Guy's men have reached me, telling me that they intend coming, and there is every indication that the dinner this year will be well attended.—Yours sincerely,

ARTHUR W. ORMOND,
Hon. Sec.

7, Devonshire Place,
Upper Wimpole Street,
W. 1.

Nurses Lawn Tennis Tournament.

Guy's have reached the final round of this tournament and are to play against the London Hospital (who are the holders of the Cup) on August 31st, at the St. Marylebone Infirmary Grounds at Notting Hill. The London have a strong team and have so far had very little difficulty in maintaining their position in the competition. We are confident, nevertheless, that our team will be strong enough to defeat them and to bring back the cup once more to Guy's.

Guy's met the Marylebone Infirmary in the semi-final on the Marylebone ground on July 26th. Nurse Stubbs and Nurse Johnson playing in the first match for Guy's won their first set 6–4, but in the subsequent sets the Marylebone pair played a far better game, and, showing an easy supremacy, won the match with the scores at 4–6, 6–3, 6–1.

Thus, as in the match against Bart's, Nurse White and Nurse Vian (our "B" pair) were left to clear up a big deficit. Guy's were one match down and six games behind. At one time it looked as if most of this deficit was going to be cleared off in the first set for Guy's led at 5–1 but a rally on the part of the Marylebone pair reduced our lead to 5–4 and we had to fight hard to win the set at 6–4. However, in the next set, Guy's won six games to their opponents two so that the final set began with each side having secured 22 games. Guy's won this final set by 6–3 and so won the tie by 3 games (Guy's 28, Marylebone 25).

THE EDITOR will, at all times, be glad to consider articles or sketches, provided that they are accompanied by the writer's name and address, not necessarily for publication. The payment that the Gazette *can offer is merely nominal. Authors who desire reprints of their papers should make their own arrangements with the printers when they return their proofs. All contributions to be addressed to the Editor, "Guy's Hospital Gazette," Guy's Hospital, London, S.E.*

The Principles of Preventive Surgery.

CLINICAL LECTURE BY MR. PHILIP TURNER.

It is usual to take for the subject of a clinical lecture one or more cases of a definite disease or injury and to consider these critically and in detail. There is no doubt that this is a most valuable and interesting way of learning medicine and surgery, but I propose to-day to depart from this plan and speak about certain general principles which are widely applicable and may be grouped together under the heading "Preventive Surgery."

General principles in medicine and surgery, and also in other branches of science and general knowledge, are usually considered less interesting than facts or observations, especially when these are new, or can be demonstrated by experiment or explained by sound reasoning. Their consideration is, however, of the greatest importance for the following reasons:—

(1) General principles, of pathology for instance, enable us to classify and summarise a vast array of facts and observations: they make it possible to see the relation between these and allow us to estimate their true value and importance. In other words they give us a broad and comprehensive outlook—a matter of the greatest importance in such wide subjects as medicine and surgery.

(2) A knowledge of the general principles of medicine and surgery will show us along which lines advance and improvement may be expected and hence will reveal many problems for investigation and research.

During the past twenty-five years or so surgery has made very great advances in all branches. Abdominal surgery, surgery of the cranial cavity and spine, and lastly surgery of the thoracic cavity have been worked at by many investigators and their possibilities—and limitations—are pretty well known, so that it would appear at first sight that surgery has now advanced to such a degree that further advances or important discoveries are unlikely. One of the objects of this lecture is to point out the direction in which some important advances can still be made and to show you that there are still fields for investigation and research, some of them almost unexplored.

Summarisation and classification of knowledge, and guidance for advance and research are of equal importance. From the point of view of medical education, both of students and of practitioners, the former should precede the latter: but, speaking generally, one commonly sees the two re-acting upon one another. Let us take an example of this from work done in our own hospital. Some sixty years ago John Hilton, one of the greatest surgeons who have ever served upon the hospital staff, delivered before the Royal College of Surgeons his lectures on "The Influence of Mechanical and Physiological Rest and the Diagnostic Value of Pain." These lectures, which are a surgical classic, enunciated certain general principles which were founded upon most thorough and careful clinical observation and most judicial and thoughtful reasoning. Their influence upon surgery has been most profound and they certainly acted as a stimulus to investigations and research which in turn resulted in modifications of the principles as originally propounded. The result is that at the present day in surgical practice we are constantly putting into use many of Hilton's principles which have become the commonplaces and every-day truths of surgery, so that we do not remember who first plainly stated them, and indeed very likely feel rather surprised that it was necessary for anyone to enunciate them at all. I am afraid that this neglect, which really is the highest compliment, is not infrequent with those who have formulated general principles. A man's name is apt to stick to a new instrument, to a new disease, or to an operation (if I had asked any of you what Hilton's name was associated with I should probably have been told of his method of opening an abscess), but it is unlikely, at any rate in the long run, to be associated with general principles, even of the most far-reaching and fundamental description.

I have no doubt that a certain number of you hope eventually to take up some special branch of medicine or surgery. To any such I would urge the importance of first acquiring a thorough knowledge of general medicine or surgery. When you have done this specialise by all means and you will find your general principles and general knowledge of the greatest use in your special work.

The human body is not constructed in independent water-tight compartments but may be compared to a very complicated and delicate instrument in which a lesion in one part may affect distant parts, or even the whole mecha-

nism, or where a general disturbance of the whole machine may produce very marked disorders in the working of some distant or special part of the structure.

Recently, as you know, a great deal of attention has been paid to a branch of medicine which is known as "Preventive Medicine," the object of which, as its name implies, is the prevention of disease rather than its treatment. Preventive Medicine includes, but is a great deal more than, Public Health. Its methods, objects and ideals have been put forward in a memorandum by Sir George Newman which has been published by the Ministry of Health and has been widely circulated. Though much has been heard of preventive medicine but little has been heard of preventive surgery. It is true that preventive surgery may be held to be included in the term "preventive medicine" but in Sir George Newman's memorandum of 124 pages it occupies 2 pages only. At first sight perhaps one is tempted to ask if there is really such a thing as "preventive surgery." I am afraid that the general public, at any rate, would probably regard the intervention of the surgeon as a break-down of preventive measures, but I hope to show you that preventive principles should continually be before us and should largely influence us in surgical treatment both general and operative. When I started to put together notes for the purpose of this lecture I was quite surprised at the magnitude of the subject. There is really material for a course of lectures rather than for one only, but I decided to try to put before you the chief outlines and main principles in my lecture to-day.

The purpose of Preventive Medicine is formulated by Sir George Newman in the following words:—

"The first duty of medicine is not to cure disease but to prevent it. In its simplest terms, therefore, the purpose of the science and art of preventive medicine is to apply human knowledge to the prevention of disease. It is the common and universal experience that life is crippled or curtailed by the occurrence of disease, which leads to a greater or less degree of disablement, incapacity and premature death. To prevent or avoid such disease is to lengthen the period of life and make it happier and more effective. Hence we may express the objects of Preventive Medicine as follows:—

1. To develop and fortify the physique of the individual and thus to increase the capacity and powers of resistance of the individual and the community.

2. To prevent or remove the causes and conditions of disease or of its propogation.

3. To postpone the event of death and thus prolong the span of man's life.

The application of these ideals to Surgery may be termed Preventive Surgery, remembering that this includes not only the prevention of surgical disease but also of deformity, disablement, and incapacity. Preventive Surgery also includes the investigation of the cause, the origin, and the commencement of disease for a knowledge of these is essential for prevention. It also includes the study of the earliest signs and symtoms of disease; early and accurate diagnosis is of the greatest importance from the preventive point of view. Another important object of Preventive Surgery is the investigation and prevention of complications and sequelæ of surgical treatment, including operations: it also aims at improvement of technique and methods which will lead to more rapid and complete recovery, in other words to better and more satisfactory results.

The methods of preventive medicine are well known and fully considered in Sir George Newnan's memorandum. In addition to those included under the term "Public Health" there are the methods which it is hoped will give us a healthier and better developed child population; the diminution of infant mortality; Welfare Centres, and the medical inspection of school children; the prevention, isolation, and treatment of infectious diseases; the inspection of factories and workshops, and the workers in certain trades for the prevention of industrial disease.

Legislation is necessary to enforce certain important preventive measures but of still greater importance is Eduoation both of the medical profession and also of the general public. The latter is extremely important for, generally speaking, the effective application of preventive methods requires the intelligent co-operation of the community at large.

Preventive Surgery will be served and helped by these same methods but requires no additions to them. Indeed one of the attractive things about Preventive Surgery is that it calls for no special departments or special officers: the principles and their application are very largely in the hands of clinical and practising surgeons.

The application of preventive principles to Surgery may be considered under the following heads:—

1. *Preventive Surgery in Children.*—Surgery in children is, or should be, largely preventive: its ideal is to completely restore the child to a normal and healthy condition; one cannot too strongly emphasis the fact that the health of the child is the foundation of the health of the community. It is important to remember that the tissues of a child, though delicate, are well supplied with blood and heal well. They are undergoing growth and development but they can be guided in their development. Let me remind you of Wolff's law which is of such importance in the consideration of bony deformities. In a standard work on Orthopædic Surgery it is stated as follows:—"Every change in the form and position of the bones, or of their function is followed by certain definite changes in their internal architecture and equally definite secondary alterations of their conformation: or put concisely, the external shape of a bone is the result of functional adaptation." Very similar alterations in structure may occur for the same reasons in other tissues, for instance in tendons or muscles. If these deformities can be detected and corrected in children at an early stage full recovery, both of structure and function, may be obtained in the growing and developing tissues; but if the deformity is allowed to progress until adult life is reached and the tissues are fully formed the structural changes are then likely to be such that recovery of function will be incomplete even after very prolonged treatment, and the structural changes will probably be fixed or permanent.

Another important thing to remember in children is the great effect of small and trivial forces when continuously applied for a long time. A good example of this is seen in the arched palate which is seen in children who have been mouth-breathers for many years. The normal palate is of such a shape that the dorsum of the tongue fits comfortably into its concavity, a fact which we can easily verify on ourselves. In mouth-breathers the tongue is not being constantly pressed against the palate and this has undoubtedly a great effect in the production of the narrow, triangular, highly-arched palate with which we are all so familiar. Here, too, we can see the importance of removing the cause of the mouth-breathing at an early stage, while development is proceeding and before the bony changes are fixed; if, as is often the case, this deformity is met with in adults after growth has ceased, removal of the obstruction cannot be expected to lead to disappearance of the deformity of the palate or of the associated structural changes in the nasal fossæ.

Circumcision is a typical preventive operation: it should be done in infancy with the object of preventing various troubles which may not become obvious until adult life is reached.

Another example of a preventive operation in children is the radical cure of hernia. The risk is trivial, the operation is simple since all that is required is complete removal of the sac, and the results are excellent. As the operation is done before the muscles have reached their full development a normal strong inguinal canal may be expected. If the operation is postponed until adult life various secondary muscular weaknesses will have made their appearance often rendering some attempt to strengthen the inguinal canal a necessary part of the operation.

The treatment of throat troubles, the importance of which is now so thoroughly well recognised, is another example of preventive surgery in children. The effects of nasal obstruction by adenoids and chronic enlargement of the tonsils in producing deafness and middle ear suppuration, and diseases of the respiratory system, as well as many other troubles is well known. It is also important to remember that various general infections may gain access to the body by the throat: the tubercle bacillus may gain access by this route and then commonly becomes manifest as tuberculous disease of the glands in the neck. It is now generally regarded as probable that the rheumatic infection enters by the same route and the same is probably true of other infective diseases also. This does not, however, mean that preventive surgery calls for a wholesale and indiscriminate removal of tonsils and adenoids, though it calls for their removal when diseased, or when causing serious trouble. Indeed, it is quite possible that future researches may show that it is desirable to preserve the tonsils whenever this can possibly be done. To those interested in this subject I can strongly recommend an interesting book by an old Guy's man, Prof. Digby, of Hong Kong, entitled, "Immunity in Health." Prof. Digby maintains, and argues his case well, that the sub-epithelial masses of lymphoid tissue, including the tonsils and also the appendix, have a very important function—that of immunising the body against pathogenic bacteria in proximity to them.

Another important source of infection in children is through septic teeth. These, as well as throat troubles, can be satisfactorily detected, and the children sent for treatment, as the result of the systematic inspection of school children. Remember that the above are only examples: preventive principles should guide us in all surgical diseases of children.

2. *Prevention of Deformities.*—The treatment of deformities has in recent years attracted great attention and has made many and striking advances; but here, surely, we can truly say that prevention is better than cure. We have only to remember that all deformities, even the severest, with the exception of some congenital cases, must have a beginning when they are slight in degree, when their cause can be ascertained and removed, and when they can be more or less readily corrected. The following instances occur to one of important causes of deformities which are amenable to preventive measures;—

Rickets is an example of a disease which' though only indirectly threatening life, is responsible for a great deal of deformity and disability. It is undoubtedly the cause of a large proportion of the deformities which are met with in childhood and in early life. As you know, a great deal of attention has been paid to the cause and prevention of rickets in recent years, and success in these measures should lead to a considerable diminution to those deformities which are so painfully frequent in children.

Closely related to these deformities are those which appear during adolesence. It is only necessary to mention Genu Valgum, flat-foot, and scoliosis, which are so frequently met with in boys and girls between the ages of 12 and 18 years. These are largely due to too great a strain being thrown upon ligaments and muscles in rapidly growing children who are often correctly said to have "outgrown their strength." The preventive measures here would seem to be chiefly in the direction of providing suitable occupations, to see that they have sufficient rest combined with exercise, fresh air, and attention to the general health. Parents and employers must co-operate in securing these.

Let me also remind you of the number of cases of deformity of the foot seen at Out-Patients. Some of the commonest are Flat-foot, Hallux Valgus, Hammer-toe, Metatarsalgia. These are largely ascribed, and I believe rightly so, to wearing tight and imperfectly fitting boots. Alterations in boots for curative purposes are now carried out in our orthopædic workshop. But why are correctly fitting boots not readily obtainable? If one sees an early case of flat-foot, one often wants to order a boot of the type described in all ordinary surgical text-books; but where is it to be obtained? I do know of a few bootmakers who make a speciality of providing such boots, but surely they should be readily obtainable and at a reasonable price. There certainly appears to be an opening for the preventive treatment of these deformities of the foot.

Another important group of deformities are those which appear after injuries, usually of bones or joints. Two examples of these are the disabling deformities after imperfect reduction of a Pott's fracture and of a Colles' fracture. The moral is that these, and most other fractures also, should be completely reduced, and here it will be noted that operative treatment may be a true preventive measure. But let us also remember that it is possible to get a perfect anatomical result after a fracture and yet, perhaps owing to ankylosis of a joint, perhaps to atrophy of muscles, get a very indifferent functional result. The latter is really the more important, and all methods that can be taken to secure this, such as massage and early passive movements, are really methods of preventive treatment.

Sometimes ankylosis of a joint may be unavoidable: when this is the case, preventive surgery demands that the ankylosis shall take place in the position most favourable for subsequent use. To take two common examples: when an elbow joint become ankylosed, say after a severe fracture or after supprative arthritis, it should be fixed by the surgeon so that ankylosis takes place with the joint fully supinated and flexed to a right angle. If the elbow becomes ankylosed with the joint extended or in a position of pronation, the arm will probably be of very limited use. The efforts of the surgeon should be directed to secure ankylosis of the shoulder joint in an abducted position. If this is so, fairly free movements will be possible between the scapula and the chest wall. If, on the other hand, ankylosis takes place in a position of adduction, the arm will be bound down to the patient's side and the use of the limb will be seriously impeded.

3. *Prevention of Certain General Surgical Diseases.*—Under this heading it will be possible only to mention a few examples. The prevention of Tuberculous disease is one of the great problems of preventive medicine but the prevention of surgical tuberculous disease is of almost equal interest to the surgeon. The Registrar General's returns for 1919 show 46,362 deaths from all forms of tuberculous of which, to take one surgical example, 376 were due to tuberculous disease of joints. One cannot here go into the various means adopted but it is obvious that this question is one of the greatest impartance to the health and well-being of the community.

Appendicitis during the same year was responsible for 2,429 deaths, many in apparently healthy young adults. There can be no doubt, even after allowing for improved methods of diagnosis, that appendicitis has greatly increased in recent years. What is the cause for this? At present, beyond certain surmises, but little or nothing is known. It must, however, be some very wide-spread and general cause for appendicitis attacks all classes of the population; brain worker and manual labourer appear to be equally susceptible. Any knowledge of the cause of appendicitis would probably allow of preventive measures but, at the present time, our efforts are best directed to early diagnosis and treatment, and to improved methods of operative technique, so as to ensure rapid and sound recovery with the absence of after effects and sequelæ. Some years ago it was seriously proposed that the appendix should be removed as a routine measure for the prevention of appendicitis. Needless to say preventive surgery does not call for the removal of this or of other normal structures or parts on the off chance of their becoming the subject of disease. It is also quite possible that the appendix may possess some important function. Professor Digby, is his book to which I have already alluded, points out that there is a large amount of lymphoid tissue in the wall of the appendix and compares this with the other sub-epithelial collections of lymphoid tissue, such as Peyer's patches and the tonsils, and assigns to it a similar function, viz., that of immunising the body against the pathogenic bacteria of the intestine. Thus it is quite possible that those of us who have been successful in keeping our appendix are really better off than if we had had it removed on the off-chance of some time or other having an attack of appendicitis.

Hernia, which may be taken as another general surgical disease, was, according to the Registrar General's return, responsible for 1,640 deaths in 1919. To me this is rather a surprising figure, and as we may assume that most of these deaths were due to strangulation, which is preventible, there must be considerable scope here for preventive surgery. The best measure is early operative treatment, if possible during childhood, or during early adult life, before secondary weaknesses have developed, when the muscles may be expected to undergo further development and thus give a firm and strong inguinal canal and abdominal wall.

I suppose that the most serious and dangerous cases of hernia are the large and irreducible umbilical hernias which so often are seen in elderly women. The hernias are large, the patients usually very obese, their viscera fatty; the coverings of the hernia are thinned and have a very poor blood supply; in short they are very unfavourable subjects for operation, and if, as so often happens, they become strangulated the operation is attended with a very high mortality. Yet, if one thinks of it, even the largest and most unfavourable of these hernias must have had a beginning, when it was small and completely reducible, and the patient younger, stronger, and in better condition. How seldom one sees one of these hernias in the early stage where operation would offer a really good prospect of success. The early recognition and treatment of umbilical hernia is thus highly desirable as a preventive measure.

4. *Prevention of Industrial or Occupational Diseases.*—It is well known to you all that certain diseases are associated with special occupations, and that the name of the latter is often associated with the former. Without attempting to make a complete list the following readily occur to one's mind:—Anthrax, Antinomycosis, Glanders, Wool-sorters disease, Glass-blower's cheek, Miner's elbow, Weaver's bottom, Housemaid's knee, Chimney Sweep's cancer, X-ray dermatitis, and many others. Most important industrial diseases are of interest to the physician, such as chronic lead or chronic arsenical poisoning to which certain trades are liable, but some, including most of the above are of interest to the surgeon. Some, such as chronic lead poisoning in the pottery districts, and "phossy jaw" among match makers are, or have been, of great frequency and importance. Others are of comparative

rarity such as chimney sweep's cancer, or are a nuisance and an annoyance rather than an actual disease such as housemaid's knee. Some, owing to preventive measures have been practically stamped out; thus in 1919 there were no deaths from glanders, though this may have something to do with the increase in motor transport. An industrial disease which is of great interest to us, viz., anthrax was in 1919 responsible for 19 deaths, while 29 were ascribed to actinomycosis.

For the prevention of occupational disease legislation, either by Parliament or by Local Bodies, is, of course, in some cases necessary to enforce needful precautions. Education of the workers is also often an important preventive measure. I daresay you may have observed with surprise how men from the neighbouring leather yards sometimes arrive in the front surgery with an anthrax pustule in a very early stage and thus in a favourable condition for treatment. This is largely due to posters which are exhibited in the various yards and sheds explaining the dangers of anthrax, the importance of early diagnosis and the necessity for immediate treatment.

A disease that can fairly be described as an occupational disease, and which illustrates the importance and evolution of preventive measures is Trench Foot. As you know, this condition was one of the new problems that was thrust upon the attention of the medical service in the first winter of the war. Enormous numbers of men were disabled, many for a long time or even permanently, during the winters 1914–1915 and 1915–1916 so as to have a serious effect upon the numercial strength of the armies. Meantime investigations were made as to the cause and prevention of the disease with the result that in in the winter of 1917–1918 trench feet were relatively much less frequent and less severe while, had the war lasted through another winter, I believe that the frequency would have been still further greatly diminished. Briefly the means taken were that men who were exposed to the danger of getting trench feet should keep their feet dry by wearing waterproof boots which should not fit too tightly: thick woollen socks were also used which, however, did not make the boots tight and puttees were woon loosely so as to avoid all constriction. Men were encouraged to keep their feet up as much as possible and especially sitting with the legs hanging down, on a fire step for instance, was avoided, while healthy circulation was encouraged by movements and muscular action. This may be taken as an excellant example of what may be called an emergency cccupational disease with sucessful preventive measures rapidly devised to meet a new situation.

5. *Prevention of Accidents.*—One cannot help being impressed, when one reads the histories of accident cases admitted to the hospital, with the frequency with which carelessness or the neglect of obvious precautions is the real cause. Sometimes it is the fault of the person who has caused the accident, sometimes it is the injured patient who is to blame, but one feels that the accident could have been prevented. The surgeon can, of course, do nothing: the two means of prevention are legislation and education of the public. Many examples of the former will readily occur to you, while, as an example of the latter, the "safety first" posters with which we are all familiar may be mentioned.

6. *Prevention of Venereal Disease.*—The vast importance of the prevention and thorough early treatment of venereal disease is obvious. The Registrar-General's figures already quoted give 1,857 deaths as due to syphilis and 89 due to other venereal disease, but these figures do not, of course, include their remote or indirect effects which are far-reaching and in this form are responsible for a great many more deaths. This scourge is being vigorously attacked but the exact methods are still the subject of discussion and controversy.

7. *Prevention of Cancer.*—During the year 1919 cancer in all situations, was responsible for 42,144 deaths, being second only to all forms of tuberculosis. There seems also to be no doubt that cancer is a disease which is increasing in frequency. It is possible that to a certain extent this may be due to the fact that owing to the improved general health of the nation by the prevention of, and diminished mortality from other diseases people now die of cancer who fifty years ago would have died at an earlier age of some other cause. possibly infectious disease or tuberculosis. However, it is a terrible figure and it is worthy of notice that there were 19 deaths from cancer under the age of one year. There can be no question that at present the best prspect of cure is offered by thorough operative treatment at an early stage. Operative treatment of cancer in all parts of the body has been most thoroughly carried out and

I do not think that much further can be expected from improvement in operative procedure and technique. In this respect there is perhaps hope for improvement in the combination of operative measures with certain accessory means of treatment, among which may be mentioned Radium, Diathermy and X-rays.

Though we do not yet know the cause of cancer which, speaking generally, is essential for preventive measures, yet, I think there are great possibilities and room for much further research and investigation along the following lines which come within the bounds of preventive surgery:—

(1) The recognition and treatment of precancerous conditions. These are best known and recognised in cases of cancer of the tongue. Let me call to your mind these cases as so frequently seen at surgical Out-patients. I think you will agree that there are in the great majority of cases two striking features (a) the presence of septic, carious, and jagged broken down teeth, and (b) the presence of the results of chronic superficial glossitis caused by old, and generally neglected, syphilis. Both these, which are certainly important predisposing causes, are preventible. I do no mean of course to suggest that epithelioma of the tongue can be abolished, but if we can imagine a population free from syphilis, in which dental caries and sepsis were non-existant, there can be little doubt that this would be a comparatively rare disease. You will remember other forms of cancer in which one can make out some definite predisposing cause. Examples which occur to one at once are:—epithelioma of the lip caused by a short hot stem of a clay pipe; epithelioma of the scrotum caused by irritation in chimney sweeps, workers in tar and similar occupations; epithelioma developing in the scars of burns as the result of rubbing and irritation; epithelioma developing in scars or dermatitis as the result of prolonged exposure to X-rays; and epithelioma of the penis as the result of sepsis, imperfect drainage, and the presence of neglected venereal disease and warts. Important work has been done lately suggesting that there are pre-cancerous conditions in the breast. If this is the case in organs which we can see, is it not probable, or even certain, that similar precancerous conditions are present in situations in which cancer is common but which we cannot see, for instance in the stomach, the rectum, and the œsophagus? What are these conditions? Can they be prevented? Can they be treated by surgical or other means before they become malignant? It would appear that a good deal is possible along these lines.

(2) The early diagnosis and treatment of Cancer. We have seen that the study of the nature and commencement of disease is included among the objects of preventive medicine and surgery. Every carcinoma in any situation and of any organ must have a commencement, and from our present knowledge we may assume that even the most serious forms must go through a stage when they are small and, what is most important, localised. This stage is short in many, the tongue for instance, but often much longer in others, as the lip. If the disease could be diagnosed and treated in this very early stage, surely one might hope for vastly improved results.

But what actually happens? Think of the cases of epithelioma of the buccal cavity which are seen at Out-Patients. What a large proportion of these are advanced and hopelessly inoperable cases when they first present themselves for treatment. If this is the case in a situation which is constantly under the actual observation of the patient, what can we expect when the disease attacks the internal organs. Think of carcinoma of the rectum. What proportion of these offer any prospect of real curative treatment when they first present themselves for treatment? Not one in ten.

What are the means open to us for attacking this problem? It is obvious that one necessity is to educate the general public to present themselves for treatment at an earlier stage. At present, and not unnaturally, patients are averse to operative treatment in the early stages of a disease where the symptoms are slight; but surely this could be largely overcome by educational methods in much the same way as knowledge has been spread among the public as to the importance of early diagnosis and treatment of tuberculosis and venereal disease.

The other method is for us to search for earlier and improved means for diagnosing malignant disease. As an example in which much work has been done in this way one may mention the earlier diagnosis of malignant disease of the stomach. A few years ago it was almost an axiom that if carcinoma of the stomach could be definitely diagnosed it was inoperable. As you know, by improved methods of X-ray examination, and by the methods of fractional

test-meals, diagnosis can be made at a much earlier stage and we can hope for still greater improvements by these means. But in other directions, carcinoma of the rectum and of the breast, for instance, there are great opportunities for improvement in the means of early diagnosis.

8. *Prevention of Chronic Infections, Absorptions and Intoxications, and diseases caused by these.*—This is an important subject which has received a great amount of attention in recent years, and indeed here we have, perhaps, to guard ourselves against ascribing too many diseases to these causes without sufficient reason.

Under this heading may be mentioned the prevention of tetanus, which in this country in 1919 was the cause of death in 155 cases. Much was learnt during the war as to the prevention of this disease. In the first few months it was exceedingly frequent. I cannot give figures, but most hospitals in France had one or more wards that were set aside for tetanus cases. Early in 1915, as a routine measure, 1,500 units of anti-tetanic serum were given as a prophylactic measure to every wounded man with the result that the onset of tetanus diminished in a remarkable manner. In the hospital to which I was attached the the cases of tetanus were in 1915-1916 only 1 in 1,500 of all wounded men, and of these cases it was established in some that the prophylactic injection of serum had been accidentally omitted. Later on the injections were increased so that there were four prophylactic injections given at intervals of a week. I do not, however, think that this had much additional effect, for in spite of the increased prophylactic measures I found that the onset remained about the same, viz., 1 in 1,500. There is no doubt that this preventive measure should be applied in civil practice. I do not mean that injections need be made in every cut or abrasion, but in dealing with wounds soiled with earth or mud, especially when these are deep or punctured, or where the mud has been ground into the tissues, even when the wounds are superficial, a prophylactic injection of anti-tetanic serum should certainly be given.

Attempts have been made to prevent other infections by similar means but without much success. We may, however, hope that further researches will reveal similar methods of preventive treatment for other diseases.

The importance of attention to the teeth and the treatment or oral sepsis has been mentioned in speaking of children. From the surgical point of view the connection between oral sepsis and various chronic inflammatory affections of the cervical lymphatic glands is perhaps the most important and most easily demonstrated. The more distant effects, such as the production of chronic joint troubles such as osteo-arthritis, are also of frequent occurrence. Let me remind you also that one sometimes sees symtoms strongly suggestive of gastric or duodenal ulcer disappear as the result of attention to the teeth. This does not necessarily mean that oral septis is the cause of these troubles but it may cause a gastritis or gastric catarrh which may resemble them. A still more important step which is engaging the attention of our Dental Colleagues is the prevention of dental caries and Pyo.rhœa Alveolaris.

It is only possible just to mention intestinal stasis and the evil effects often remote and obscure which may arise from septic absorption from the alimentary canal.

Another source of infection and absorption which is of great importance from the preventive point of view, and which rather strangely, does not seem to have received the attention which it merits, is the skin. "Cutaneous sepsis" as it may be called is continually before us, is easily seen and investigated and its effects are usually obvious. Septic absorption from the skin certainly gives rise to serious disease of the lymphatic glands, even sometimes apparently to Hodgkin's disease. Then we have to remember the infection of the glands which may take place as the result of pediculi—such a common trouble in neglected children. It is also necessary to remember the various infective diseases which may gain access as the result of insect bites: Malaria from mosquitos; typhus and trench fever from lice; and sleeping sickness from the Tsetse fly among others. From the surgical point of view let me remind you how often in cases of acute infective osteo-myelitis in children one finds a source of infection, a boil or other septic spot on the skin.

Infective diseases of the skin, which are largely preventible, are also often fatal. In 1919 carbuncle and boil were responsible for 31'7 deaths and erysipelas for 660 deaths.

In the case of carbuncle and boils, treatment by a vaccine which prevents further infection is a true preventive measure.

Can absorption and infection take place through the uninjured skin? It is difficult to

answer this question. True, many cases of erysipelas appear to be spontaneous, and one often finds a chronic septic infection of glands without any obvious septic cutaneous spot, but it is quite possible that such have been present and have been overlooked.

The above facts show us the importance of attention to skin lesions, including the destruction of insects and pediculi, as a preventive measure.

9. *Preventive Principles in Operative Surgery.*—When we remember that Preventive Surgery includes the prevention of complications and sequelæ, and also the improvement of technique and methods which will lead to better results, we appreciate the fact that these principles are of very great practical importance in Operative Surgery. Indeed they should be always before us. Examples of "preventive" operations have already been mentioned, and and it is easy to think of many others. For example, a patient who has had appendicitis has his appendix removed between attacks; by this procedure we prevent further trouble which is certain to occur and also prevent the serious risk of prolonged disability, or death from peritonitis.

The principles which guide us in operating can only be briefly stated, but the following are particularly important.

The first is the avoidance of septic infection. The work of Lister is undoubtedly one of the greatest pieces of preventive work ever done. Post-operative sepsis cannot be said to have been entirely abolished, and I suppose will never completely disappear; but whenever we meet with a case of septic infection of an operation wound it behoves us to enquire carefully into the cause and then to take measures for its prevention in other cases.

The next great consideration is the prevention of shock, which at the present day is the serious danger of many operations, especially when important viscera, such as those of the abdominal cavity, are involved. Much has been done by Crile and others in this direction, but there are still opportunities of increasing our knowledge of this condition and of the means for dealing with it.

With the above we may associate methods adopted to increase the safety of anæsthesia, including the most suitable anæsthetic for special types of patient and for particular operations. The prevention of certain complications of anæsthesia, such as pneumonia and bronchitis, is also of very great importance.

Before recommending operation it is often necessary to take into account the patient's age, general condition, occupation, and position in life, and to adopt methods which will give the best prospects of increasing his efficiency. In other words, bear in mind the ultimate functional result.

As regards the actual operation preventive methods should guide us throughout. The incision should be carefully planned so as to give the best possible access for investigation and treatment. For example: in abdominal surgery a median incision is usually best where the diagnosis is uncertain; this gives the greatest facilities for examination and most conditions can be treated through a median incision. Avoid unnecessary damage to, or interference with, normal structures, especially vessels and nerves, and treat them with the greatest care: do not tear or lacerate tissues; clean cuts are as a rule to be preferred as causing less injury. Do not cut muscles across if it can be avoided: draw them on one side or split them in the direction of their fibres. Deal with aponeuroses in the same way. Remember possible complications and sequelæ and seek to avoid them. For example, careful closure of an abdominal wound and, if possible, a valvular incision through the muscles will prevent a subsequent disabling ventral hernia.

The prevention of sinuses and fistulae, such, for example, as may occur after draining an empyema is of great importance. Here systematic after-treatment by a Bier's cup will often help closure of the wound and expansion of the lung, and thus prevent, not only troublesome sinus, but also diminish the likelihood of subsequent pulmonary troubles.

The prevention of certain post-operative complications such as thrombosis and that tragic occurance a pulmonary embolism also offers a field for further investigations and development. Remember, too, that many of the post-operative chest troubles such as pleurisy and pneumonia are really of embolic origin. Prevention of post-operative abdominal adhesions is also a matter which demands attention.

Let me also draw your attention to a subject that has a greater preventive significance than appears at first sight. One of the most puzzling cases one can meet with at out-patients is a patient with some abdominal trouble who

has had an abdominal operation some time before by a surgeon at another hospital or very possibly another part of the country. The patient does not know what was done and probably cannot give the slightest information. There is perhaps a median scar and that is all one has to go upon, though to know what was done before may be of the greater importance both for diagnosis and treatment. This will show you that the keeping of accurate records and their accessibility may have a preventive significance.

In the case of insured patients this information should be included in their record of illnesses; but in others the only suggestion that one can make is that written information in which the condition found and the treatment adopted should be given to the patient for the information of any doctor who may afterwards be called upon to treat some subsequent illness.

On the Folly of Over-statement.

During the last year my knowledge of life has been limited to first hand observation of the Borough and of my own particular suburb, while for events which are shaking the heart of London and the great world beyond. I have had to rely on the twin voices of the *Daily Mail* and the *Evening News*. My isolation was lately borne in upon me by the thought that I had only seen three examples of the Sandringham Hat, one upon the attendant at a coco-nut shy at Olympia, one on an Oriental student who entered my carriage at Warwick Avenue, and the third worn by a gentleman at London Bridge, who was otherwise quite well dressed. Something was amiss, for was I not told that the factories at Luton were working day and night in three shifts in an effort to cope with the demand? Obviously, the folk among whom I moved were too humble or too low down on the waiting list to be supplied as yet, and had, perforce, to wait till their ambitions could be realized. To see the change that had come about I must visit the West End. I went West, and I was distressed to see that the majority of mankind were still going their way unconcernedly under the cover of the slovenly Homburg, the absurd Bowler, or the still more ridiculous Topper. Here was a hat combining lightness with firmness, smartness with comfort, equally suitable for Buckingham Palace or the Palais de Danse; yet they would have none of it. Why were they so blind to what was best for them?

Simply, I think, because human nature is averse to being rushed, and with most men gentle persuasion will affect much more than extravagant assertion. No fanfare of trumpets will flatten the walls of a modern Jericho; it may bring the defenders to peer down over the parapets, but it will fail to dislodge even a solitary brickbat. A company prospectus in the *Times*, backed by a plain statement, will result in a good many shares being taken up, while the florid eloquence of the bucket shop circulars which inundate everybody on the medical and clerical registers, dooms them inevitably to the waste paper basket. One of the most successful advertisements of our day was that of a soap, which stated from every hoarding that it would not wash clothes. There is an irresistible appeal in this modesty. The proprietor of such an article must be serenely confident in its virtues if he can blazon abroad what must surely be its only defect. To-day the more sensitive among us are made to blush by the exhortation, "Mothers! Nurse your babies! if you can't, get Nestlé's." And very nice too. But alter the punctuation to "Mothers! Nurse your babies if you can't get Nestlé's," and the result is futile bombast that would not succeed in selling a single tin.

And so it is with all things in life. We distrust that which is thrust upon us with a voluble exposition of its merits, as we distrust the cigar that is offered us by the man in the train; the broader the gold band the more we distrust it. The precept which tells us not to look a gift horse in the mouth is one of good manners and not of good sense. So it has been with the Sandringham hat. Had it been pushed with a certain amount of reticence so that men first realized it had arrived when they saw other men wearing it, had it even been difficult to obtain, it might have come to stay. For it is the Balham Brummel who relies on the fashion column for his information, it is the office Adonis who takes its advice; and once a male fashion is adopted by the dressy as apart from the well dressed, it will go no further. Men have adopted the Homburg in the last ten years simply because they liked it, and not because they were told they were ill dressed without it.

In medical and surgical literature we are all familiar with the glowing article describing a new method, the technique which never fails, the uniformly perfect after results, the umpteen consecutive cases without a death. The pity is that most of them are really sincere, and really true, or nearly so, but they entirely fail to gain our confidence by the very perfection of the results they describe. We all have a good deal of first hand experience of medical and surgical work, and we know that there is always the human element in the patient and the practitioner intervening between us and the millenium. Things will always go wrong when least expected. We have been the admiring witnesses of great improvements,

but none of these have reached perfection. They have been but one more salient thrust forward in the battle to alleviate human suffering, and have been in turn the road head from which further advances have been possible. And so we are not carried off our feet by the author's enthusiasm, but we feel we should like to have a quiet chat with the house surgeon. It is rather the man who takes us into his confidence, dwells on his difficulties and how they were overcome, his failures and the lessons they taught him, that carries us with him in his final conclusions. Failures often teach us much more than successes, and it is as much our duty to tell others where we have gone wrong as it is to share with them in our triumphs. It is the boast of Medicine that there are no trade secrets.

In 1916 there appeared a book by Carrel and Dehelly on the treatment of infected war wounds, which in a way marked an epoch in the surgery of the war. The account of the very thorough inquiry into the action of antiseptics on which it was based, was a model of critical scientific investigation. The description of the bacteriology of gunshot wounds, and especially the vital distinction that was drawn between contaminated wounds and infected wounds, was in every way admirable. The conclusions were logical. But the description of the method in application was couched in terms of unrestrained eulogy. Generalities replaced data. That most fallacious of methods, the quotation of "typical" cases, was the chief reference to the practical working of the treatment, and neither in the book nor, I think, subsequently, was a large unselected series of consecutive cases ever published. The Carrel treatment spread through the French army like the measles. Each attack usually lasted four months instead of four weeks, but it carried complete immunity against subsequent attacks. Very much the same story was repeated in the British Army, And yet the Carrel treatment has fallen iuto undeserved disrepute. Under working conditions it cannot be carried out in its entirety, and complete sterilisation is not always obtained. But it does furnish us with a possibility of physiological drainage which is hard to attain by any other means than by laying a wonnd open from one end to the other. In the surgery of acute osteomyelitis, amputations for contaminated lacerations, and some compound fractures, it is of the greatest service. In spite of its merits, a good method has gone the way of the Sandringham because it failed to fulfil the too optimistic claims of its partizans.

Take at the other extreme an article by Harry Platt, on the use of nerve grafts and facial tubes, which appeared in Vol. VII. No. 27, of the *British Journal of Surgery*. Here is a series of 26 cases, of whieh every one that has been traced has been a failure. Anyone who has read that article will not fail to admire Mr. Platt far his candour, nor think the worse of him for his lack of success, but rather feel, on laying down the journal, that something has been added to the literature of surgery. It is only right that we should know that these methods are useless, yet because of this unseemly bashfulness in the reporting of failures they continue to be recommended in surgical text-books. (1)

This rose tinted outlook is as old as medicine itself, for listen to Sir Thomas Browne. (2) "I wish herein that Chymists had been more sparing: who over-magnifying their preparations, inveigle the curiosity of many, and delude the security of most. For if experiments would answer their encomiums, the stone and quartan agues were not opprobrious unto Physteians: we might contemn that first and most uncomfortable aphorism of Hippocrates (3); for surely that art were soon attained that hath so general remedies, and life could not be short were there such to prolong it."

Physicians and surgeons of an experience that enables them to speak with authority could do the younger generation a great service by a little destructive criticism. There are many idols which stand tottering on their pedestals, ready at a gentle push to vacate them to more worthy successors. The young seeker after truth has now to thread his way among a maze of superlatives. We need the iconoclast.

W. H. OGILVIE.

(1) See the latest English book on the subject—"Injuries of the Peripheral Nerves" by Souttar and Twining.

(2) Vulgar Errors. Book I., chap. vii., last paragraph.

(3) "Ars longa, vita brevis."

On being Funny.

If at this time of the year you see a man wandering about with a haggard, sleepless, look, you may hazard a guess that he is an editor fulfilling his thankless tasks. For now is the season upon us when all men conspire to rob editors of their scant repose! While other men dream blissfully of holidays to come, or, tanned and rejuvenated, dream equally blissfully of holidays just past, the editor stalks, sad and unheeded, on his ubiquitous search for copy. There is no sporting news obtainable, for the cricketers have already oiled their bats and laid them aside, the tennis players have no worlds left to conquer, and months must yet elapse before the Rugger men get properly into their stride. Where then can we find material with which to fill our pages? To whom can we appeal?

It was with such sad thoughts running through our mind, that we sat despondent at the editorial desk ruefully contemplating the prospect of a Gazette which was to consist of an attenuated "Passim" and a number of announcements of births (and thanking our lucky stars that it did not seem

to be a close time for births at any rate) when there entered to us our sub-editor bearing in his hand a scrap of newly acquired copy. We clutched at it, as a drowning man is said to clutch at a straw, or a hungry man at a testmeal, and read—this:—

Dear Mr. Editor, I have no doubt
You find at times your job is none too light,
(For "Passim" takes a lot of padding out,
And critics talk a lot but seldom write).
But really, Sir, while tears are in my eye,
At thought of nights of rest you must be losing.
I often wonder why you never try
To be a bit—a tiny bit—amusing?

Wisdom no doubt we need, each one of us,
And subtle problems for our mind's delight,
And articles, and cases to discuss,
Much as we need our paraffin at night.
Think not that I would ever dare to mock
At all your gifted scribes have got to say,
But by the shades of Brookhouse and of Cock,
Give us a smile to take the taste away.

Is it the drought has dried the fount of fun,
And made your pages—pardon—somewhat dry?
Or do you think perhaps it "isn't done"?
Or have you lacked the courage, Sir, to try?
Whate'er the cause, I trust you'll hear the plea
Of one who looks to you with faith and hope;
Let yourself go a bit—you're bound to be
At least as funny as the *Guyoscope!*

That was all. There was no signature, not even a pseudonym. There were just these three pleasant little stanzas, admirably written, and such as we had long given up hoping for—but on what an unwelcome theme! Can you fancy us trying to be funny under such circumstances? Here are we, not even knowing where our next GAZETTE is coming from, and racking our brains to think of some forgotten source of copy—and we are asked to be funny. It simply cannot be done. Even at the best of times, when we are in our happiest mood we find it difficult to be funny. Of course at times we may be unconsciously amusing in what we have meant to be a perfectly staid and respectable "Passim," but any effort we may make to be intentionally witty only results in our being all the more stupid and sad.

No, gentle scribe, we have not inherited the pen of Brookhouse, neither the pencil of Cock. Nor can we, sir (or is it madam), turn ourself to verse with that delightful ease which you yourself display in this short poem.

The question of your hidden identity puzzles us not a little. You have made yourself so pleasantly unpleasant that we would gladly have more to do with you. At first we thought you might yourself have worn the editorial mantle, for your verses show that you realise far more than does the average reader, how much work goes into the fortnightly compilation of the GAZETTE. But we could not place you among any of the erstwhile Editors whose acquaintance we enjoy. Our next clue took us to consider contemporaries of Brookhouse and Cock, but we got no further with this. Then a student of caligraphy further baffled us by assuring us that yours was a woman's handwriting, and we had to start afresh. We had at last to admit ourselves beaten. But will you not take pity on us and send us some more verses and you name? For we must have some more of your verses if we are going to make the GAZETTE as amusing as you wish it to be. If you can help us to amass a staff of regular and industrious contributors, we will endeavour even to out-punch *Punch,* but alone we are helpless.

You suggest we be "at least as funny as the *Guyoscope,*" a paper which can afford to take as many months over its preparation as we do days (for *Guyoscopes* come and *Guyoscopes* go, but we go on for ever), a paper, too, which when it does appear is made up chiefly of libellous parodies and poorly veiled innuendoes. We would have you realise at once that we do not intend to publish such copy as this in the GAZETTE. We will not have it said that the GAZETTE is but an imitation of the *London Mail.* But we will willingly print anything that you may send us in which the spark of humour glows.

As firstfruits of this policy, which you have thrust upon us, we publish below two sets of verses. It happened that when your poem arrived our Sub-Editor was in an irresponsible mood and suggested that we should both of us reply to you in verse, though neither of us (as you will doubtless gather) had ever written verse before for publication.

Acting on the motto of "Thrice blessed is he . . . ," we will get our blow in first:—

As Editor, we're bound to write
Refuting your poetic slight.
You know so much about the game,
Have you (we wish we knew your name)
E'er padded "Passim" half the night?

For if you have it is not right
You should upbraid us in our plight,
You probably were just as tame
As Editor.

Still we will take your gage and fight
To make our pages gay and light.
And you, we hope, will do the same;
From you a verse each week we'll claim
To match the stanzas we'll indite,
As Editor.

Lastly as an antidote to all the sad solemnity of this long and meandering article which your poem has enabled us to write, we offer you an "Ode to Night," the Sub-Editor's song, written in his own inimitable, breezy style—

A spectral gloom invadeth
The precincts of the Park
And Stygian black pervadeth
A College gaunt and stark.
In fact, the Boro' sleepeth,
And stilled is London's roar,
While o'er the silence creepeth
A solitary snore.

The sparrows, once a-twitter,
Upon our stately oaks,*
Have ceased. The lamplight's glitter
Shines on no rowdy blokes.
'Tis night (to put it briefly).
Rest, all around, I see;
But I am grousing, chiefly,
Because there's none for me.

I'm feeling quite despondent,
(Though cats are on the spree),
Because a correspondent
Has issued a decree.
He bids us "Now! Be witty!"
I'd hate to say him nay,
But writing this 'ere ditty
Hath snatch'd my sleep away.

All Editorial Sanctums
Are somewhat dull at night.
With empty and with lank tums,
We sit in ours and write——.

[Ed.—Look here, this is about enough! Sub-Ed.—*All* right, I've almost finished.]

O curst be this effusion!
[Ed.—Hear, Hear.]
This rhyming habit grows,
A snare and a delusion.
I think I'll stick to prose.

*Poetic licence! They are not really oaks, but I had to get a rhyme for "blokes."

[Surely there are plenty of rhymes for "planes," —Ed.]

Guy's Hospital Golfing Society.

SEASON 1921–22.

A General Meeting was held on July 29th, 1921, at which Dr. Cameron presided. The minutes of the last meeting were read and confirmed, and a brief resumé of the season's events discussed.

The following officers were elected:—

President, Dr. Cameron (re-elected).

Vice-Presidents, Mr. Bromley, Mr. Davies-Colley, Dr. Eason, Mr. Fagge, Dr. Fawcett, Mr. Hopson, Mr. Hughes, Mr. Malleson, Mr. Ormond, Mr. Steward.

Committee, R. S. Hodgkinson, J. R. A. Moore, F. W. Schofield, T. E. Duckworth, D. B. Whitlock.

Captain, K. Hooper.

Hon. Sec. and Treasurer, F. J. Smith.

Dr. Cameron repeats his prize of golf balls to be competed for during the ensuing season.

Reviews.

Guy's Hospital Reports. Vol. LXXI. (Vol. I, 4th Series) No. 3, July, 1921. (Oxford Medical Publications). Subscription £2 2s. 0d. net., Single Copies 12/6 net.

Several very interesting articles appear in the third volume of the new Reports. Dr. Ryle and Dr. Bennett has given us their long promised papers on the results of the series of test meals which were done on a number of students at this hospital. From the curves so obtained they have deduced the limits within which a curve should lie if it is to be regarded as normal.

Dr. Campbell writes of two cases of acholuric jaundice. One of these seems to have been a spasmodic case but the other was definitely familial, for Dr. Campbell was able to trace eight other cases in this family in four generations.

Mr. Slesinger has analysed a large number of consecutive cases of fracture of the upper extremity seen at Fracture Outpatients. He gives some valuable hints on the treatment of the various types of fracture met with in this limb.

A short paper by Mr. Turner suggests the use of the head of the fibula as a fixed point in the measurement for shortening of the lower extremity after fracture. He points out how much smaller field of error this landmark offers compared with the points which are in commoner use.

These have been to me the most interesting of this series of papers but there are several others all well

worth reading and thinking over, whose excellencies I have no space left to record here. This volume is a fit companion for its two predecessors, which is high praise indeed.

Manual of Ophthalmic Operations. Maynard. (Messrs. E. & S. Livingstone). Price 25s. net.

Maynard begins this excellent book by giving details for preparing patients for eye operations, the sterilising of the eye instruments required for such operations, and the choice of anæsthetic. We think that he is rather inclined to underestimate the risks of sepsis and also the value of general anæsthesia, for the book is written to be of use to those who are in other places besides India.

For the actual description, indications, methods and after-treatment of operations we have nothing but praise. No stone is left unturned to elucidate any knotty point and nothing is left to the imagination. To assist in this there are many pictures, but better still are a number of plates for stereoscopic vision. This in itself is excellent, but our regret is that few people will possess a stereoscope or have one at hand when required. This, however, will be the fault and to the disadvantage of the reader.

The book should prove of value to all, not only to students and nurses, but to the practitioner and eye surgeon.

Manual of Ophthalmic Practice. Maynard. (Messrs. E. and S. Livingstone.) Price 21s. net.

We have no hesitation in recommending this volume to everybody, whether intending to take up eyes as a speciality or merely to understand eyes as a general subject.

The book is well written and clear in explanation —there is no chance of any misunderstanding. Particularly do we like Maynard's chapters on cataract, and the conjunctiva and its diseases. Every group is taken in a logical manner, beginning with the anatomy and physiology of the part under consideration and then considering the diseases to which that part is subject. A very excellent chapter indeed is written on refraction—this at all times being perhaps the most difficult of ophthalmology for the student to comprehend. This difficulty is made clear to anyone who reads with intelligence.

It would not be fitting to close without mentioning the excellent coloured plates in the volume and also the numerous other pictures.

A word of praise is due to the printers for the most excellent manner in which they have produced both volumes—the printing being large and clear.

Football.

The Kent County Rugby Union Challenge Cup.

Shortly after the Duke of York had left the Hospital and the Park in the state of a pre-war garden party, four representatives of the Rugby Club, and of the "A" team in particular, proceeded to Chatham in order to collect the above Cup, which, owing to the threatened "Triple Alliance" strike, we, as finalists, are holding jointly this year with the R.E. Chatham.

We were put up at a local hotel and eventually arrived at the mess, and were duly introduced to the R.E.'s big rugger men. After the King had been toasted, at the end of a typical mess dinner, General Tullier made a short speech in which he formally handed over the Cup to Guy's and concluded his speech by toasting Guy's. This was followed by a most boisterous singing of "For they are Jolly Good Fellows."

Mr. Wilkins, the Secretary of the Kent County Rugby Union, was present.

The "A" team captain responded to the toast on behalf of the Hospital, and expressed a hope that we should be able to return the compliment and entertain the R.E.'s representatives in London after defeating them in the final next season.

The Cup now resides in the "Spit," but we were very disappointed not to find "Guy's" inscribed on the Cup, as being holders on any previous occasion, and it will now only appear jointly. It is to be hoped that before long Guy's may be inscribed as sole holders for at least one season.

Not the least important of our activities whilst at Chatham was the game of rugger in one of the numerous ante-rooms of the mess. Judging by the way our representatives played, the Cup would undoubtedly have been ours, had the final been played off. However we only succeeded in reducing a couple of large waste-paper baskets and a bowler hat into mere fragments.

When you have read all this you will be wondering how the Cup really reached the "Spit," but it is a fact that those who went to get it returned with it intact.

Publications Received.

Burma Medical Times, Hospital, Hospital Gazette, New Zealand Journal of Health and Hospitals, Indian Medical Record, Nursing Times, Prescriber, The Stethoscope, Magazine of (R.F.H.) London School of Med. for Women, U.C.H. Magazine, Brit. Journ. of Dermatology and Syphilis.

Birth.

CROOK.—On 9th August, 1921, of Mrs. F. W. Crook (neé Perry), wife of F. W. Crook, M.R.C.S., L.R.C.P., of 11, Torrington Sq., W.C.1, a son.

Ed.—A. T. R.

GUY'S HOSPITAL GAZETTE.

VOL. XXXV., No. 865.] SEPTEMBER 3, 1921. [NINEPENCE.

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Passim.

DURING the last months Death has levied heavy toll on Guy's. Week after week it has been our sad task to record the death of yet another of her sons. This week our obituary columns are again filled, and filled with the praise of one whom Guy's is grieved to lose—Stephen Charles Olver. Though we did not enjoy the personal friendship of Olver, yet we could not fail to note his popularity and the esteem with which he was regarded by those who knew him best. We can well believe all that Dr. Symonds writes, in his addition to the obituary notice, of the cheerfulness and never-failing faith and hope, which Olver retained throughout his trying illness. It was just this cheerfulness under all trials that endeared him to his friends here at Guy's.

WE are gratified to find that one of our fortnightly plaints has been seriously considered. Almost in every Passim we fill two columns airing our own or other peoples' grievances. More often they are other peoples', for to tell the truth we are often far from feeling all the bitterness which we endeavour to infuse into our tirades. But it is unusual for us ever to hear of anything being done in response to our agitation, and we often wonder if we are not wasting our own time and the GAZETTE space.

But this week we have evidence that some of our suggestions made for the common weal do find a sympathetic hearing. The hon. secretary of the Rugby Club has written to us assuring us that something is being done to remedy the lack of accommodation for spectators at Honor Oak Park. In his letter (which may be found on page 352) he tells us that our idea of a banked temporary stand is not a new one. Apparently there was some such stand built in 1912, then blocks were used instead of extra duck boards. Our reason for suggesting the tiers of boards rather than blocks last week, was that at the back of our mind we had the idea that boards would distribute the weight more evenly, and so would not cause deep furrows in the turf.. But we are quite willing to leave this decision to others who have a more specialised knowledge of the practical side of the question. It is enough for us to hear that something is being done to remedy last year's defects. We are especially glad to find that rope seats have been arranged, and we trust that in response to these improvements the Guy's home matches will be even better attended than they were last year.

There is only one other matter, which, in passing, we would like to mention to the Hon. Secretary. Last year, we were grieved to read in one of the leading London newspapers a slighting article on the hospitality which Guy's offered to the representatives of the public Press. Apparently, although arriving before the advertised start of the match, the reporter found that the stand was full and the ropes thronged, and that no provision had been made for the Press. So he had to put up with an uncomfortable hour and entirely inadequate view of the match, and in his report he reflected his discomfiture and disgust. So, Mr. Secretary, please see that this year there is plenty of room for the Press, so that we may hear no more of the inhospitality of the Guy's Rugby Club.

WE must commiserate with the nurses on having the victory snatched away from them in the last round of the tennis tournament after their having gone so far. The Cup, which the "Nursing Times" presented for competition has been won once again by the London Hospital. Though our teams played well on Wednesday they could not penetrate the steady defence of the London Hospital nurses. Time and again the games went to deuce but our opponents had all along just the best of the exchanges, and Guy's were in the end defeated by what was undoubtedly a better team. The scores do not flatter Guy's but in considering them, it must be remembered that the London team had none of their games given away to them. Each game was well contested and in many we only lost after deuce had been called several times.

A BOOK has just been sent to us for the Wills Library which deals with the progress of medicine in China during the last century.* It is said that long years ago, before Hippocrates, even before Asculæpius, the art of medicine was born in China. If this be true then Chinese medicine must have advanced very slowly indeed, for less than a hundred years ago when Thomas Colledge (who was a pupil of Sir Astley Cooper's) visited China as a ship's surgeon, he found that practically nothing was being done for the relief of sufferers from disease. The most painful and the most crippling ailments were left helplessly alone. He was so impressed by this neglect that he determined to set up a hospital at Macao, to see what he could do to alleviate this suffering. He was soon joined by Peter Parker, a Yale Graduate, and for some years they carried on their charitable work alone. In 1841, Parker came to England and brought with him a collection of paintings of various cases he had met with in China. These he presented to Guy's and they may still be seen in the Gordon Museum. About 1840, Colledge persuaded two other medical men (one a Guy's man—William Lockhart, F.R.C.S.), and from these small beginnings has grown the present great medical missionary system which has brought relief from suffering, both physical and spiritual, to many thousands who had been left so helpless.

This is not the only side of the work of the missionaries which is portrayed in this book. We are shown, too, how the Chinese are themselves being trained in medicine and in nursing, and we are led to expect that in the near future we shall find the Chinese giving to science valuable original contributions such as those which we now receive from Japan, and which fifty years ago would have been regarded almost as impossible. Lastly Professor Balme appeals to more men to take up this type of work and so ensure the permanence of the movement.

THE book on the History of Small-pox, by Dr. James Moore, whose receipt we acknowledged last week, has now been placed in the Wills Library, where it may be consulted on application to the Librarian.

*China and Modern Medicine, by Harold Balme, F.R.C.S. 5s. net.

WE have received a very interesting letter (which we print on another page) from Mr. Grant Massie, the Arthur Durham Travelling Scholar who is at present visiting the world-renowned clinics of Crile, of Cushing, and of the Mayos. He gives an account of the technique and of the wonderful results of the operative treatment of exophthalmic goitre as at present practised in America. Not only is his letter very readable, but it repays reading, and we hope that it may not be the last account of his studies which we will receive.

WE could never understand why it was that the few people who did venture to send to us contributions in a lighter vein were so anxious to hide their identity. We had thought that it was either modesty or shame which caused them to avoid their due recognition. Now we have found that there is an even more potent incentive which compels them to remain anonymous.

Later on in this GAZETTE we publish a parody on Osler, which was given us only after we had promised strictly to preserve the writer's incognito. It is obvious to anyone what compels this man to remain unknown. It is the greatest of the primeval emotions—Fear. For if he were found out, we dread to think of his punishment at the hands of an infuriated nursing staff A more insulting and a more scurrilous article we have never had the pleasure of publishing.

We commend, and we will respect his anonymity, but we warn him that we will not be held responsible to anyone for his sins.

Correction.

In our last issue we stated that the Physical Society's Prize of £10 for the best Paper read during the Session was won by Mr. M. E. Iban. Apparently no such gentleman exists. We offer our apologies to Mr. M. E. Shaw, who was the prize-winner.

Interesting Cases in the Medical Wards

DRS. FAWCETT, RYLE AND MARSHALL.

25 Stephen.—Aneurism.
33 " Arthritic congenital syphilis.
36 " Chronic abscess of lung.
44 " Hodgkin's disease.
34 Esther.—Paraplegia.
44 " (Cot) Pleural effusion.

DRS. HURST, HUNT AND SYMONDS.

6 Addison.—Infective endocarditis. Cerebral embolism.
10 " Tabes.
18 " Aortic endocarditis.
12 " Congenital heart.

DR. BEDDARD.

21 Stephen.—Rupia.
17 " Streptococcal anæmia.
19 Esther.—Auricular fibrillation.

DR. FRENCH.

13 Mary.—? Hodgkin's disease.

Papers by Guy's Men.

H. W. Barber, M.B.: (1) Case of Epidermolysis Bullosa, p. 85. (2) Case for diagnosis, p. 85. *Proc, Roy, Soc. Med.* Sec. of Dermat. Vol. xiv. 1921.

A. H. Todd, M.S.: Case of Chronic Arthritis of the Knee in a Syphilitic Boy. *Proc. Roy. Soc. Med.* Sec. of Surgery, p. 167.

A. W. Sheen: Case of Finger Injury, *Ibid.* 166.

Sir Charters J. Symonds, K.B.E., C.B., C.M.G., M.S., M.D.: Discussion on Pruritus Ani. *Ibid.*, Sub-section of Proctology, p. 178.

J. W. Eyre, M.D., F.R.C.S., and C. H. Marshall, M.B., B.S.: A case of Trypanosomiasis. Treated by intrathecal serum. *B.M.J.*, 1921, p. 284, ii.

W. M. Mollison, M.Ch., F.R.C.S.: Paralysis of Eye Muscles in connection with Mastoiditis. *Clinical Jour.* 1921, p. 508.

Change of Address.

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Publications Received.

Architectural Association Journal, Hospital Nursing Times, St. Thomas's Hospital Gazette, New York State Journal of Medicine, Current Research in Anæsthesia and Analgesia, Medical Science, The Prescriber.

Obituary.

STEPHEN CHARLES OLVER.

IT was with feelings of great sorrow and regret that we heard of the death of Stephen Olver on Sunday, July 31st. In the short span of 22 years he had achieved much. The son of an old Guy's man on the staff of the National Dental Hospital, Mr. S. Holloway Olver and Mrs. Olver, of "Crantock," Selcroft Road, Purley, he was educated at Falconbury School, Purley, and Uppingham, where he gained the Annual Home Exhibition and became Prefect and Captain of his House in 1917.

From Uppingham he was recommended for a commission in the Royal Engineers and was posted to the R.E., O.T.C., at Bedford, in August, 1917. He passed out third in the list and was gazetted to the R.E., Signal Section. In May, 1918, he went to Palestine and Syria, and after serving on the front there was posted to G.H.Q. In October, 1919, he joined this hospital. It was not long before his capable and striking personality asserted itself among his fellow students. As Captain of the 2nd XI. he served the Hockey Club in the 1919–1920 season, becoming a member of the 1st XI. and Hon. Sec. of the club for the season that has just passed. In his work he showed every promise of becoming a worthy member of his profession.

He had been ailing since Christmas last, but paid little heed until his condition interfered with his work. Thinking he had been overdoing things, he consulted Dr. Symonds. But it was worse, than he thought. The ultimate diagnosis was cerebellar tumour. He was removed from Stephen ward to St. Thomas's Hospital for operation, where, despite all the great care and sympathetic attention that was lavished upon him, he died. We have this comfort in his loss, that everything was done for him that could be done, in that magnanimous spirit of brotherhood that graces the medical profession throughout its membership.

The many that knew him will always remember "The Duke," for his was one of those personalities this world can ill afford to lose. Ever happy, humorous and cheerful, he spread the light of his character over all his surroundings, so that all who knew him were drawn to him, despite themselves, in genuine esteem and love. Wherever there was a gathering for the common weal of Guy's there was he always to be found in his place, pleading its case in his own inimitable way; and his views were always worth listening to. Those who attend the meetings of the Physiological Society will remember his bright and witty argument in debate. He was essentially a Guy's man—one of those Guy's men to be numbered among whose friends one counts it a privilege.

He could mix laughter with his thoughts and with his speech, as well on his sick bed as in health. His cheery courage at the last was that of a "gallant English gentleman." In extending our sympathy to his parents we have only to say that he will not soon be forgotten among this generation of Guy's men, to show how much we thought of him, for we loved him well.

NOTE BY DR. SYMONDS.

The writer made the acquaintance of Stephen Charles Olver only at the commencement of his last illness, and had the privilege of seeing much of him from this time until his death on July 31st 1921. From the first Olver wished to know himself the nature of his illness, and its gravity; he desired to take the burden of anxiety as far as possible upon his own shoulders. For this reason, when he was first informed that his condition was a serious one, for which an operation would probably be necessary, he kept the news to himself until the diagnosis was actually settled, in order that the pleasure of his last week end at home should not be marred for his parents by any fears of impending calamity. During that week end he did not abate the usual buoyancy of his spirits, but entered into all the affairs of the moment with accustomed zest.

Throughout his whole illness he preserved intact his spirit of this unselfish philosophy. Despite this handicap of pain, and an affection of the eyesight which deprived him of the solace of reading, he continued in the last days before the operation continually to find happiness in his surroundings, and in so doing he gave much to others. Later when he was often suffering great discomfort he would always react to the stimulus of company, and would discuss subjects of common interest with his physician before alluding to his own symptoms. In these he was keenly interested, yet never with any morbid view of curiosity. The treatment of his illness he left entirely to those in whose charge he had placed himself without ever a word of doubt or fear. The prospect of death he once discussed with the writer, quietly and frankly as one who had faced it before in battle.

In him Guy's has lost one worthy of its best traditions, his parents their only surviving son

STEPHEN CHARLES OLVER.

Athlete's Heart.

Read before the Guy's Pupils' Physical Society, Thursday, February 3rd, 1921. by

MAURICE E. SHAW.

Mr. President and Gentlemen,—I have chosen a title for my paper which is, perhaps, too brief to cover the subject with which I propose to deal. The modern tendency of authors appears to be to select a title which has little connection with the story they have to tell. Many authors, however, have adopted the simpler plan of using for a title the name of their chief character. This precedent I have followed for it is athletes and heart affections and especially their interrelationships that I wish to discuss.

I am afraid that I shall be able to tell you little that is new. At one time I had hoped that I might be able to give you the results of a few simple investigations which I had (and still have) in mind. Unfortunately I have not had time to proceed with them and they must be left to some other occasion. I shall therefore confine myself to giving you my views on the effects of athletic exercise on the healthy normal heart; views which have resulted from a fairly close acquaintanceship with various forms of athletic sports, and from a rather incomplete examination of the literature of the subject. The medical journals of all countries contain many contributions dealing with this subject and my researches into them have necessarily been limited by lack of time and opportunity. I have, therefore, only referred to certain papers and articles by acknowledged authorities, and upon their observations and conclusions my paper is largely based.

I must confess that my chief reason for choosing this subject was that it has, for some time, been one of absorbing interest to myself. It is, however, also a subject of great importance to medical men, whether they be consultants or general practitioners, and the fact that it is not dealt with in the ordinary text books as fully as, I think, it deserves must be my main excuse for inflicting my views upon you to-night. We have all heard of frequent cases of so-called "heart strain" in young healthy athletes. We are often told that so and so "strained" his heart in the sports at school; or that a University Blue crocked up during his training as the result of "straining" his heart. We do not, however, hear the medical evidence on which the diagnosis of "heart strain" was made. The term is a convenient one for the family doctor to use and its too frequent employment has spread abroad amongst the lay public—and to some extent too, I am afraid, amongst our profession—a number of misleading and entirely erroneous ideas.

In the first place I want you to be quite clear what I mean when I speak of athletics. It is not easy to define athletics. We all have a vague impression of what the word means but it is applied to so many different forms of exercise that it is a term which cannot be used with any scientific precision. I shall not attempt to define it. All I can say is that I am referring to the more strenuous and exhausting forms of physical exercise—usually of a sporting and competitive nature. More especially am I thinking of the various kinds of racing in which human beings indulge—rowing, running, cycling, etc., for it is these that throw the greatest burden upon the heart. Football, hockey, lawn tennis, and kindred sports also come into the picture. In general I mean all forms of exercise which tend to exhaust the human body.

I said before that it was my intention to examine the effects of such pastimes as these on the normal, healthy heart, and here, at the very outset, we are faced with a fundamental difficulty. For what is a normal heart? Lewis tells us that the normal heart cannot be strained. "If strain of the healthy heart" he says, "exists, it is no more than a curiosity." Inasmuch as the teaching of Lewis has had so profound an effect upon our conception of cardiac disorders I think that it will be worth while to examine more fully the evidence upon which he bases the statement I have quoted, and to compare it with the opinions of others who have had peculiar opportunities of observing the medical histories of athletes.

Neither Mackenzie nor Lewis hold that a healthy heart can be strained, that is, damaged. The estimation of the fitness of the heart I shall deal with later. At the moment let us assume a healthy heart and see on what grounds it is stated that it cannot be strained or damaged by excessive exercise. Lewis considers that the reserve power of the heart is so enormous that it can withstand any strain that it may be called upon to bear. He lays down, to use his own words, that "The burdens imposed by physiological acts upon the heart, however heavy those burdens may be, never exhaust the heart's reserve." Again he says, "It is the full supply of blood to the muscles that will fail, and not the heart, when the call is excessive."

These statements sound reasonable, for it would not be in accordance with the economy of nature for the human body to be provided with an organ unable to bear the strain of "physiological acts." But exercise is not the only form of extra burden that can be imposed upon the heart. Consider for a moment the case of a valvular defect, for example insufficiency of the aortic valves. It was at one time supposed that so great was the extra work

thrown upon the heart by an aortic reflux that this lesion seriously diminished the heart's reserve power and was itself responsible for the ultimate failure of the heart. Such a view might be represented in the following diagrams (Figs. 1 and 2) in which the first column in each case represents the normal heart and the second column the heart labouring under the extra load imposed by an incompetent aortic valve.

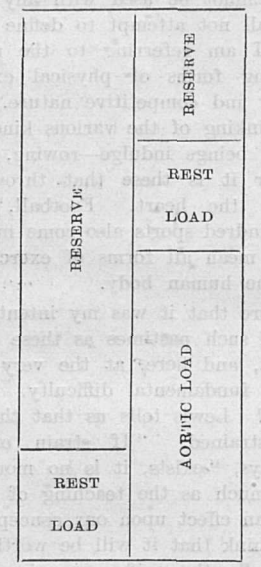

FIGURE 1. (Modified from Lewis.)

Here (Fig. 1) the reserve power is greatly diminished by the excessive load of the aortic lesion. Under conditions of full exercise the diagram might be modified thus :—

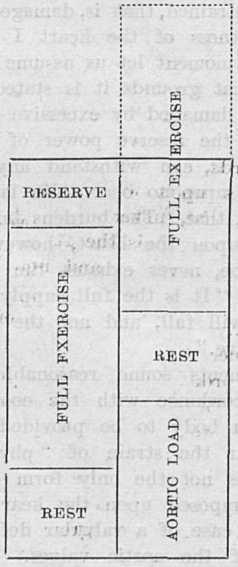

FIGURE 2. (Modified from Lewis.)

In Fig. 2 the full exercise load is seen to be too much for the heart with the valvular defect, and this is what actually occurs, but not, according to Lewis, for the reason represented in the diagram. The reserve power of healthy cardiac muscle is so great that, if we can imagine an hypothetical case of a healthy heart which has to deal with an incompetent aortic valve, the effect of exercise upon such a heart would be more accurately represented by this diagram:—

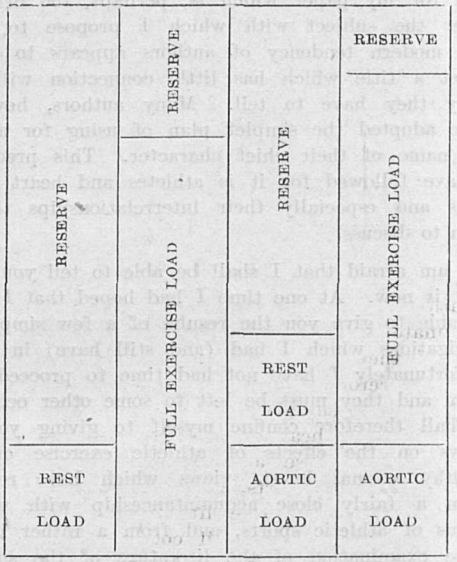

FIGURE 3. (After Lewis.)

Here the first two columns refer to the normal heart, the second two to our hypothetical heart with normal muscle but a damaged valve. According to this diagram (Lewis) a healthy muscle is quite equal to dealing with any mechanical obstruction such as is imposed by strenuous exertion or a valvular defect. Hypertrophy, of course, will occur and I shall have something to say on hypertrophy later. But in the end the heart is little, if at all, impaired by the extra load it is called upon to bear as the result of the regurgitation of blood into the ventricle during diastole. As a matter of fact, as I have said, the result of heavy exertion upon a heart which actually presents the clinical picture of aortic regurgitation would be a failure of the heart to cope with its extra burden, as seen in the second column of figure two. The reason for this is not the valvular lesion but the defective power of the myocardium. In practice any infection which causes damage to a valve causes more or less damage also to the musculature of the heart. Indeed the muscle may be damaged without the valves being affected, and all degrees of myocardial insufficiency may be met with either with or without a corresponding valvular lesion. This is repesented by Lewis by this diagram (Fig. 4).

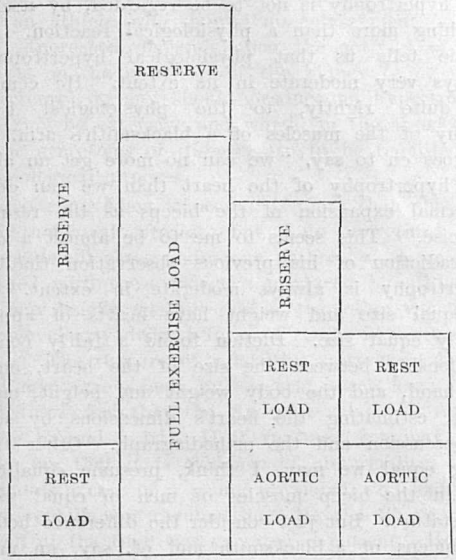

FIGURE 4. (After Lewis.)

In the third column the reserve power is diminished by myocardial damage and in the last column the reserve power has completely disappeared —that is the available work is completely expended in dealing with the normal physiological requirements of the resting body plus the extra load imposed by the valvular lesion.

I have gone into this question of the heart's reserve power in some detail because I believe that a clear conception of it is essential if we are to consider the question of heart strain. Although I am at one with Lewis in the importance he gives to myocardial conditions in producing failure of the heart, I am not sure that I can accept, unqualified, his statement that the normal heart cannot be strained. As I have said it all depends on what is meant by normal. It is very easy to say that heart strain is a *sign* of an abnormal heart. But there seems to be evidence that such strain may occur, although admittedly it is not common, in the hearts of those who, judged by ordinary clinical standards, have had no illness to account for a weakened myocardium. No doubt in a large number of cases of so-called heart-strain in athletes, if you enquire carefully enough you will elicit a history of rheumatism. It may be no more than "growing pains" or perhaps a mild and transient attack of Chorea or even only a tendency to sore throats, but it will be sufficient to indicate the probable source of the myocardial trouble. It is impossible to refute the statement categorically, nor is it necessary. The fact remains that we may at any time meet with a case of "strain" in a patient whom we have passed as having a sound heart, and this possibility should impress upon us the importance of searching with the utmost diligence for a history of rheumatic or other infection in those who consult us as to their fitness for indulging in the more violent forms of athletic sports.

Whatever may be the truth about the "normal heart" all the evidence goes to show that it is exceedingly rare for exercise, however strenuous, to cause permanent damage to the heart of a healthy athlete, especially if training has been prolonged and careful. Collier, who has had unrivalled opportunities for observing athletes at Oxford, in that his high reputation causes most athletes to consult him when worried about their hearts, has seen few cases in an experience extending over more than thirty years. Such cases as do occur are mostly of a transient nature and do well under suitable treatment. Whether their hearts ever return to their previous efficiency it is difficult to say as they usually are advised to give up racing and so on and to take to more leisurely occupations. If they follow this advice they can lead a mildly athletic life without harm, and indeed with great benefit to themselves. If they neglect it, it is unlikely that they will again consult the same doctor for symptoms which are produced by failing to follow his advice.

One of the earliest systematic enquiries into the effect of athletics on the health was that of Dr. Morgan (1869). Out of 255 living Rowing Blues—that is oarsmen who had raced over the Putney-Mortlake course—he extracted personal evidence from no less than 251. He found little evidence that these men had in any way damaged their health either at the time of their exertion or later in life. In those cases in which the evidence of damage seemed reliable the cause was shown to be inattention to training or rowing a race when unfit or stale. Dr. Morgan, I am glad to say, completely established the longevity of rowing men. There is no evidence to show that the lives of rowing men or runners are shorter than those of any other class of men.

A more exact investigation was undertaken by Dr. Michell in Cambridge, in 1904. He made observations on 1,200 rowing men, 400 football players, and a few running men, during periods of training. He found a lowered pulse rate, an increase in the size of the left ventricle and, as training progressed, a decrease in the difference between the pulse rates before and after exercise. He found that in those whose training agreed with them there was a rise in the red blood count up to six million and that, under such circumstances the colour index was raised. A fall of body weight, a sure indication of staleness, was accompanied by a fall in the colour index. The mid-day blood pressure was about 20 millimetres of mercury above the pressure when just

awake and lying in bed (100—120). Two hours after exercise the pressure was about 10 points above the mid-day pressure and subsided below the mid-day pressure on lying still for 10 minutes. There was a slight rise in temperature after exercise.

Dr. Michell noted a certain number of cases of overstress. Of those that did not recover under treatment the majority were due to sudden exertion when untrained. In these no left-sided enlargement was noticed, but occasionally there was evidence of right-sided enlargement with venous engorgement. Far less common were certain cases in athletes of long standing and in these left-sided enlargement was found. But by far the most important observation that he made was that persistent dilatation was only seen in untrained men who had had diphtheria or rheumatic fever. The combination of absence of adequate training and past history of infection is extremely significant, for there can be no doubt that one or other of these is at the bottom of the majority of cases of strained heart. Personally I do not quite see how we can call an untrained heart an abnormal heart. I feel sure that if you took eight healthy untrained rowing men—men who had been leading sedentary lives for some months without much exercise, but still strong, healthy men—and put them into an eight and told them to race a trained crew over the 'Varsity course the result, provided all the crew raced their hardest, would be one or more "strained hearts." I don't say much permanent serious damage would be done. The man might be well enough in a week or two, but if he repeated the experience the damage would be increased. Sir Thomas Lewis may tell us that the man has had some infection which has damaged his myocardium. But why go out of the way for an explanation when a simple one is readily at hand? The heart is a muscle. In many ways it behaves like other muscles. If you go into the gymnasium after years of inactivity, and attempt to emulate the prowess of your school days you are not surprised if you come out with a pain in your leg, arm, or back. You have strained a muscle. You don't immediately say, "I must have had some infection which gave me a mild myositis and this weakened the fibres of my biceps." You assume that the normal healthy tone of your muscles has become diminished with disuse and that this has made them less resistant to sudden stretching and violent contraction. Surely it is so also with the heart. The heart has tone. The greater the tone the more resistant are its fibres to distension. It is not inconceivable that an atonic heart muscle should be stretched beyond the limits of its normal elasticity.

I should like now to consider what are the effects, so far as it is possible to estimate them, of severe athletic exercise on the heart. There can be no question that athletics cause hypertrophy, and that this hypertrophy is not to be regarded, by itself, as anything more than a physiological reaction. Mackenzie tells us that physiological hypertrophy is always very moderate in its extent. He compares it, quite rightly, to the physiological hypertrophy of the muscles of a blacksmith's arm. But he goes on to say, "we can no more get an abnormal hypertrophy of the heart than we can get an abnormal expansion of the biceps as the result of exercise." This seems to me to be almost a direct contradiction of his previous observation that such hypertrophy is always moderate in extent. Men of equal size and weight have hearts of approximately equal size. Dietlen found a fairly constant relationship between the size of the heart, on the one hand, and the body weight and height, on the other, estimating the heart's dimensions by means of percussion and the orthodiagraph. Other things being equal we may, I think, presume equality of size in the bicep muscles of men of equal weight and stature. But just consider the difference between the biceps of a blacksmith and of, say, an unathletic clerk, whose skeletons are of approximately equal dimensions. It would, I think, be no exaggeration to say that the biceps of the blacksmith might be twice the size of that of the clerk. Is that hypertrophy only moderate in extent? It may not be abnormal, but it is certainly not moderate. I would not say that athletes' hearts are often, if ever, twice the normal size, but there seems to be evidence that quite considerable enlargement may be found in athletes who are perfectly sound in wind and limb. The same thing is known in animals. Dr. Collier in 1892 quoted the opinion of Mr. George Fleming, a veterinary surgeon, in support of his contention that hypertrophy was common in animals from whom great muscular effort was constantly demanded. Mr. Fleming actually stated that the weight of the heart of the famous racehorse Helenus was 15½ lbs., the normal weight being 9 lbs. Is this only moderate hypertrophy? Dr. Collier has not noticed that this hypertrophy is attended by any inconvenience or bad effects, although it is commonly considered to bring evil consequences in old age. Further evidence of the nature of this hypertrophy is provided by an experiment of Külbs in 1906. This observer took two dogs. Using one as a control, he subjected the other to severe muscular strain over a considerable period. He found that the increased weight of the heart was proportionately greater than the increase in weight of the skeletal muscles (using the control animal as a standard). Both ventricles were thickened and, on microscopical examination, there was no appreciable increase in the size of the fibres nor any increase in the interstitial tissue. I think we may safely conclude that hypertrophy of the ventricles in athletes is a normal physiological process and that its presence need cause no

concern. Rather should we be disturbed if we came across an athlete who showed no enlargement of the heart. Increased demands upon the activity of the heart, as on the activities of the kidney (*e.g.*, after nephrectomy), do and should produce an hypertrophy which may be extensive and which, in the absence of signs or symptoms of disease, are to be regarded as a physiological process.

Heart-strain, when it occurs, is more than this. It is a pathological process, but I do not think we can include all cases under one pathology. I am only concerned with those varieties produced by athletics, but I may briefly mention one or two other varieties. The most clearly defined form of strain is rupture of a valve. The rupture of a healthy valve must be an exceedingly rare event, but several cases have been recorded. I feel that the "normal valve" is rather like the normal heart. If it ruptures you may reasonably say that it is evidence of abnormality. Allbutt quotes a case of a young physician, who had had neither syphilis nor rheumatism. He was 35 years of age, and at the time was carrying a patient. He was taken with a sudden sensation as if something had given way in his chest. Dyspnœa developed immediately, and a bruit which had never before been heard developed from that hour and lasted to the end of his life which was prematurely ended. This is a dramatic picture which is not likely to deceive the physician. More evidence is, I think, required to show that rupture can occur in a patient free from the taint of spirochæte or rheumatococcus.

Another type of strain, affecting chiefly the aorta, was described by Allbutt in the "St. George's Hospital Reports" as long ago as 1870. He noticed the gradual onset of aortic disease in labourers working in the forges and docks in Leeds and he accounted for this by a gradual dilatation of the aorta produced by raised blood pressure from exertion extending over long periods. We must, however, remember that the connection between aortic disease and syphilis was hardly realised in 1870, and it is not improbable that syphilis (and possibly rheumatism, too) played an important part in these cases. There is, however, some experimental evidence to show that a raised blood pressure, acting over long periods of time, may be at any rate a contributory cause in the production of arterio-sclerosis, for this condition has been observed in animals which have had their blood pressures artificially raised by the administration of drugs. Athletics, however, are rarely continued over a sufficient number of years, or over a sufficient number of days in each year, to justify their being considered as contributoy to this class of heart strain.

Goodhart referred to another class—the neurasthenic, but this need not detain us, for Collier has not observed neurasthenia in the athletic type and does not believe it to be a contributory cause. The type, when it occurs, is largely the result of injudicious treatment, on the part of the doctor, of some general disturbance which has upset the cardiac mechanism. Once the patient can be convinced of the soundness of his heart, recovery is rapid.

In athletics the increased burden falls chiefly on the right side of the heart. The blood returned by the great veins is enormously increased, and the distention of the alveoli of the lung impedes the pulmonary circulation. The result, even in a healthy heart, is right-sided dilatation. It is a common experience of all athletes, after a hard race, to suffer from cough and even slight hæmoptysis is not unknown, though I have never come across it. Only a few weeks ago I saw a man who, untrained, had stroked a crew in a hard race. For some hours afterwards he complained of what he called "hay fever." His eyes and nose were watery and he was coughing up a copious thin secretion—all, I think, manifestations of venous congestion. Another indication of venous congestion in athletes was noticed by Leonard Hill—cyanosis. This is partly due to deficient oxygen output per beat, and can be remedied in a most striking way, as Leonard Hill has shown, by the administration of oxygen prior to the exertion. It seems to me that we can draw no hard and fast line between this dilatation and real heart strain. We see all degrees. I have observed it in myself. Before the war I would recover from the effects of a hard race in about a quarter of an hour. My recent experiences have showed me that it now takes nearly three-quarters of an hour—probably an indication that a more prolonged period of training is now necessary. Some men may be knocked up for a day or two and then recover completely and take part in further contests with impunity. Others whose symptoms last longer, are driven to consult a doctor and become classified as cases of heart strain. The vast majority recover; some relapse if they pursue their athletic careers, but few have any permanent disability. In those cases that present persistent symptoms of cardiac insufficiency we must presume that the fibres of the heart's muscle have been stretched beyond their normal elasticity—that is, their capacity to recover their normal dimensions has been destroyed and the heart is permanently weakened. I think this hardly ever occurs in a trained heart. A diseased heart or an atonic heart may be affected. The difference is that the atonic heart, atonic, that is, from disease, can be trained up to a higher point of maximum efficiency, whereas the diseased heart will probably break down during the process of training.

It must not be thought that the left side escapes. I have already referred to the marked hypertrophy of the left ventricle. Stress of the left side occurs either from constriction of the peripheral vessels or accumulation of residual blood with increasing disproportion between the contraction volume and the

output. Actual strain from stretching of the ventricular fibres beyond their elastic limits probably never occurs.

There are certain other effects of exercise, not directly concerned with the heart, to which I will briefly refer. The lungs increase in size and capacity. This condition has been referred to as physiological emphysema and hypertrophy. It is certainly not an emphysema, and the term ought not to be used. I think it is more of the nature of a distension than a hypertrophy, and I should prefer to speak of it simply as an enlargement. Its practical importance is that, while it lasts, it may obscure those signs on which we are accustomed to rely in estimating the size of the heart.

Mosso's experiments on dogs, proving the production of fatigue toxins, are of some interest. Inasmuch as these toxins are known to be capable of stimulating the production of antitoxins, it would be interesting to note the effect of injecting a dose of antitoxin into an untrained athlete called upon at short notice to take part in some contest. As it seems likely that normal training consists largely in immunising the body against these toxins, such an experiment might meet with some success.

Collier has drawn attention to the frequency of albuminuria in athletes. After severe exercise it is a common and almost constant feature to which no prognostic significance need be attached. Venous congestion with heightened peripheral pressure seem not unlikely to produce such a phenomenon.

We must now pass on to a rather more detailed consideration of how to recognise such conditions as I have mentioned. The symptoms need not detain us long. Allbutt describes the case of a boy of 17 who was mountain climbing when he suddenly collapsed. His pulse was 130, respiration shallow and fequent. The skin was cold and cyanosed. The veins of the neck were dilated and the right cardiac dulness was two fingers to the right of the sternum. Temperature 102°. There were dulness and a few rales over the middle third of the right lung. All the symptoms cleared up in three weeks, and in six months' time he was as fit and well as he had ever been. I could quote other cases, but this case is, I think, sufficiently typical. I should like, however, to say a few words about the physical signs that these patients present.

In the first place signs of enlargement are looked for. I am not one of those who place much reliance in percussion, partly, I admit, because I am myself rather lacking in the necessary skill. I am more influenced, however, by a realisation of the fact that percussion is usually unnecessary. We are accustomed to percuss the right and left borders. The position of the left border indicates, as a rule, the approximate size of the left ventricle. A much more accurate indication is the position of the outer margin of the maximum impulse of the apex beat. Dietlen, by radiographic examination, demonstrated that the apex beat was usually felt in the intercostal space above that in which the apex was seen, but Lewis finds that the outer limit of the impulse corresponds very accurately with the left border of the heart as depicted by the orthodiagraphic shadow. Evidence seems to show that percussion, tested by the orthodiagraph, is very fairly accurate in skilled hands. Nevertheless, we must admit that the majority of hands are not skilled, and I think we should pin our faith to the apex beat rather than percussion. When we percuss the right side we are percussing the right auricle. The chief indication for percussing the right side of the heart is to ascertain the *position* of the heart and not the size of its chambers. A large right-sided auricle gives other signs of greater moment. You will remember in the case I quoted of the boy who collapsed when mountain climbing that the veins in the neck were distended. What the apex beat is to the left ventricle, the veins of the neck are to the right auricle. In this particular case the dulness was percussed out as two fingers' breadth from the sternum. You could have diagnosed a dilated auricle without percussion, but not without dilated veins in the neck. In estimating the size of the heart, then, I would stress these two points. Let the apex beat be your guide to the size of the left ventricle and the veins in the neck your guide to the size of the right auricle. I need hardly add that there are other signs of right-sided dilatation which must be diligently searched for, venous pulsation, large liver, and so forth. In athletes the apex beat is almost always further to the left than the normal position, and may I here add that the normal position of the apex of the heart bears no relation to the nipple, either in the male or female. In men of equal size the nipple has been shown to be anything from 8—13 centimetres from the nipple line. The normal position may be taken as 3—4½ inches from the mid-sternal line in the fifth interspace. In athletes, after exercise, evidence of the overburdened state of the right side will be found. These should pass off in anything from a few minutes to an hour, or, as we have seen, in cases it may take days or weeks.

It is well known that, under stress of exercise, all normal hearts develop a tricuspid systolic murmur, and I think no one will deny that the murmur is due to tricuspid regurgitation brought about by dilatation. I do not know whether any members of the Society present have views on the physical principles underlying the production of murmurs. If they have I hope they will not keep them to themselves. For my own part I should feel inclined, as a working hypothesis, to assert categorically that all endocardial buits are the result of the blood being forced from a narower into a wider channel. Dr. Collier has found a murmur in athletes who have overworked

themselves which presents fairly constant features. It is usually not heard at all until the patient has been made to run round the room or up and down stairs. Then it appears over the middle of the sternum and is conducted up the left side of the sternum to the pulmonary area and is systolic in time. The first time that Collier found this bruit in a man he got the opinion of Sir W. Broadbent, who wrote to him as follows: "The murmur is produced in the pulmonary artery or its conus arteriosus, and is the result of a temporary dilatation of the right ventricle and conus. . . The dilated conus is in contact with the chest wall instead of having a layer of lung between; and during systole it is slightly flattened against the chest and this leads to an eddy in the current and hence the murmur." Except that I am not prepared to admit that an eddy, as such, produces a mummur, the explanation seems to fit the facts. But the difficulty of distinguishing the origin of basal systolic murmurs—or indeed any systolic murmur—makes them of little value in prognosis. In the case of this pulmonary systolic murmur, Collier draws attention to the fact that it is practically always associated with abnormal breathlessness, and this is the important fact. I do not think the stethoscope is of much assistance in deciding whether such a patient is likely to be fit to continue his athletic career. In any case it is an instrument which has in the past been allowed to play too important a part in estimating cardiac efficiency. In this way the bruit has been regarded as the chief evidence of disease or incompetence. There are a number of bruits, systolic in time, which it is impossible to distinguish, ætiologically. Who is to say whether a mitral systolic is endocardial or exocardial? Even in this murmur which we have just been discussing I cannot say I feel certain that Broadbent's explanation is correct. There may be causes of bruits of which we know nothing at all. At any rate, we know enough of systolic bruits to know that we can learn little from them as to the future progress of a patient in whose heart they are heard.

The physical signs of dilatation should be used, I think, with some caution. In athletes we are most likely to meet with right-sided dilatation, and it is usually taught that epigasric pulsaion is a sign of dilation of the right ventricle. If by this is meant that the two conditions are often present at the same time, no doubt this is correct. It may be that in these cases dilation causes the pulsation. Collier has noticed it in a number of his cases. But it is equally true that epigastric pulsation can be present in the absence of any enlargement of the heart. The same is true of the diffuse impulse which is usually attributed to dilatation of the left ventricle. Here, again, it is quite true to say that a dilated ventricle is not infrequently accompanied by a diffuse impulse at the apex. But it is equally true to say that a diffuse impulse is rarely accompanied by dilatation of the ventricle. Moreover, there are no physical signs that will clearly distinguish dilatation and hypertrophy. Usually we may take it that where there is one there is also the other. If rapid enlargement occurs with cyanosis, dyspnœa, and œdema, we are right in saying that dilation has occurred. If the enlargement is gradual we may find it impossible to say which process is mainly responsible.

As I have said, the prognosis of these over-exerted hearts is good unless permanent damage has been done, and this is rare. If strain of the left side occurs (Collier records a few) the prognosis is graver and treatment longer. I think all cases of left-sided strain could probably be traced to some predisposing cause, *e.g.*, rheumatism or diphtheria. The treatment presents little difficulty. The principles of treating heart cases are the same for all conditions; the details of their application vary. The heart requires exercise. No cardiac patient should be put to bed unless it is absolutely essential. We have seen the importance of tone in heart muscle. It is the toneless heart that is liable to be strained. The first object of treatment should be to restore the tone to the heart muscle and to maintain it at its maximum efficiency. To secure this the patient should be up and about. Any heart case that can walk about without distress should be encouraged to do so. The heart will always give warning if it is being called upon to do too much. It may be necessary to keep a bad case in bed for a day or two, but he should be got up and made to walk in the open air as much as possible without bringing on dyspnœa and fatigue. The exercise should be gradually increased, and in a week or more the patient should be able to carry out all his normal activities. It would be wise to forbid all forms of racing; moderation in meals, alcohol and tobacco are obvious adjuvants.

There is one more aspect of the subject to which I should like to direct your attention before I close. Supposing that a man is brought to you to be examined as to his fitness for athletics, how is that examination to be conducted? Not many years ago I think a large number of physicians would have examined the man thoroughly by inspection, percussion and auscultation, and, if no abnormality had been found, if the borders of the heart were within the normal limits, if no bruits had been detected, they would have been content to pass the patient as fit. There is to-day an increasing tendency to lay stress, not on the supposed mechanical disadvantages under which the heart is working, but upon the capacity of the heart to do work. Doctors now are making patients run upstairs and are carefully counting their pulses before and after exertion. All this is to the good, and it is not, I think, too much to say that the examination of the heart is *never* complete without some simple test of its capacity for work. I said when speaking

of bruits that murmurs were no indication of cardiac insufficiency. Some bruits indicate a valvular defect For example, a mitral diastolic means a stenosed mitral valve. But having heard the bruit with your stethoscope, are you in a position to tell the patient how much work he may do with impunity? You cannot have any idea how much myocardial defect accompanies the valvular lesion unless you test the myocardium. Valvular disease *per se* is insignificant. A simple mitral regurgitation may be neglected if the patient can emerge successfully from a severe myocardial test. As Lewis so rightly insists, it is only because of myocardial disease that the hearts of patients with valvular defects fail.

I am not aware of a good test for myocardial efficiency. We require, it seems to me, a standard test so that all observations can be compared and mean results calculated. At present each doctor has his own test. One will make his patient run round his consulting room, another will send him upstairs, another out into the street. It is as if we were all taking blood pressures using columns of different fluids—one in millimetres of mercury, another in millimetres of water, and yet another in millimetres of alcohol. We not only want a standard test, but we must have a simple one without bulky or complicated apparatus, and also, if possible, one capable of precise numerical interpretation. If any of you have the patience to wait for the lift, or the energy to go up the stairs in Hunt's House, you will find on the top floor a piece of apparatus that Dr. Hunt is using for this sort of purpose. You all know it. I expect I think it has some obvious disadvantages, for it does not fulfil the conditions I have already laid down. It is bulky and not easy to move; moreover, it would be impossible for all doctors to have such a structure in their consulting rooms.

My own idea of what is needed is something much simpler. All I suggest is a number of blocks of wood of about 6 inches thickness, so made as to fit one on the top of the other. My test would be for the patient to raise himself from the ground on to one of these blocks of suitable height so many times in one minute. For example, a man of 200lbs. weight raises himself ten times on to a one-foot block in half a minute. His pulse before was 72; after 96 He has done 2,000 ft. lbs. in half a minute for a pulse rate rise of 14. As far as each individual patient is concerned, I do not think the question of foot pounds of work done matters. It is sufficient to give him the same piece of work on other occasions and to observe the differences. But at present we have no figures to tell us what rise of pulse rate to expect for a definite piece of work. We do not know, for example, whether a heavy man reacts to the work of lifting his own weight more or less than a light man. These, as a matter of fact, are some of the things that I had hoped to be able to tell you to-night. There seem to be numerous possibilities. I do not think anyone knows whether a man lifting his own weight through, say, a foot space, by means of his arms gets a higher pulse rate reaction than when he lifts the same weight through the same distance with his leg (as in the test I have suggested). I should imagine that most men would sooner exhaust themselves in doing work with their arms than with their legs, even though the work was exactly the same. Indeed it is almost an obvious remark, but I think the pulse readings would be interesting. Why should there be a difference? If a man does a certain amount of work he loses so much heat His potential energy is used up and a certain number of calories are evolved. Physiologically this number of calories is constant for a given piece of work in a given time. Why, then, should the metabolism demand increased rate of beat from the heart according to which muscles perform the work? I am aware that this is guess work. I have not made the observations, and I may be all wrong, but my impression is that arm work calls forth a higher pulse rate than leg work; it is certainly more rapidly exhausting.

If sufficient observations of this sort could be made I am sure we could devise some test for cardiac efficiency on the lines I have put forward which would be of incalculable benefit My object at the moment, however, is to emphasise that fact that the capacity of the myocardium should always be investigated with thoroughness. In the absence of precise data as to pulse rates, and so on, each must make his own standard, using himself if he is fit, as a *corpus vile* for his experiments. The stethoscope is not to be neglected, but its place is rather in diagnosis than in prognosis, and the presence of a bruit (unless it be diastolic in time) is not to influence the evidence of a good tolerance to exercise. Many a mitral systolic murmur has kept a healthy man an invalid in the past when a test would have shown that his muscle was as competent as ever.

A recent paper by Hunt and Dufton in the "Quarterly Journal of Medicine" describes a method of measuring dyspnœa. In a modified form this can be carried out for cardiac patients and may be a valuable indication of improvement. In the experiments of Hunt and Dufton a bicycle ergometer was used, but there is no reason why the work should not be done in the way I have suggested for estimating cardiac efficiency. In fact, Dr. Hunt is now engaged in measuring dyspnœa in cardiac patients as well as taking pulse readings, but he is not measuring the actual work done.

I am afraid my remarks have been somewhat disjointed, and I am doubtful what sort of impression they have conveyed to you. My own conclusions are that heart affections in athletes are rare and that when they occur a diligent search will often bring to light a history of some previous infection. That

strain occurs occasionally in healthy hearts I do not deny, but, where disease is absent, lack of adequate training will be the commonest cause. The importance of training cannot be over-emphasised. Doctors are often consulted by anxious parents who think that their boys are likely to strain their hearts at school. Heartstrain in schoolboys is the rarest thing in the world, for they are nearly always in good condition. Dr. Lambert, at Harrow, has seen no cases in which traces of organic disease could not be detected. At the Universities conditions are different. Alcohol and tobacco are not unknown, and conditions of life lead to many a flabby atonic heart. Provided you have excluded rheumatic fever and diphtheria and have insisted on the essential importance of careful and prolonged training, I think you may safely advise anyone to indulge in the most violent athletics without fear of athlete's heart.

A New Account of an Old Ailment.

By A. B. Rowser.

(With profuse apologies to the late Sir William Osler.)

NURSOSIS

(Amœbiasis Ancillaris, Browser's Disease).

Definition.—A disease occurring in both acute and chronic forms, and characterised by a more or less (often less) permanent cardialgia. The virus is produced by a protozoon parasite, the *Amœba ancillaris* (or nurse), and is spread by contagion or air infection to the male inmates of hospitals.

History.—The disease, although it has existed in Egypt since early Biblical days, does not seem to have been widely known in England before 1855. It is said to have been brought to this country by the British Expeditionary Force returning from the Crimea.

Etiology.—The infectious agent was first isolated and described by Sir William Harzia, of Cairo, in 1851. It is an amorphous, slowly moving organism, which is indigenous to most hospital wards. Several different types of parasite have been described, but it is now believed that these are merely different stages in the life-history of the same amœbic organism.

The earliest form in the life-history, yet observed, is the *A. agni* which has, however, been found by most observers to be non-pathogenic. As cultures get older a rather more virulent strain *(A. probationis)* develops but it is only after about two years in this stage that the parasite reaches its most dangerous form. About this time it is seen suddenly to develop a curious submandibular appendage which characterises it as the fully developed *A. nutricis principis*. This is a most virulent type, and nocturnal infections by it are relatively common among house-officers. Some observers say that they have been able to trace the transformation of this type in a few cases into that of *A. cerulei*, a much less harmful parasite, characterised by its bright blue colour.

The disease attacks young healthy males in their third decade. It is widely prevalent among medical students. In a series of 3,291 cases at the Johns Hopkins Hospital no fewer than 2,959 (or 93 %) were medical students. Only a few students who happen to have a strong natural immunity are able to complete their years of training without being infected. It is interesting to note that the disease has existed so long in Egypt, that Egyptian students are now completely immune.

Symptoms.—(a) *Subacute or chronic form.* The patient loses his ardour for work. He is seen lounging gracefully in the Park or Colonnade at such hours as 11.30, 12.15, or 1 o'clock. At the approach of the infecting agent his pulse quickens, he flushes, and he may develop a transient unilateral ptosis. It is not unusual to find that he suffers from multiple infections. (Usually the number of infections varies in direct proportion with the number of wards which the patient visits.)

(b) *Acute form.* This occurs among young males (often medical students) who have been "warded" for some other complaint. Thus, while in a poor state of health, the patient is subjected to the virus in an undiluted form over a prolonged period. As may be expected, his symptoms are relatively much more severe than are those of the chronic form. He becomes infatuated with a given organism, and cannot bear that it shall be ever out of his sight. He invents pretexts to bring it to his bedside. At last he may become so demented that he proposes to marry it.

Diagnosis.—The acute form rarely presents any difficulty, but the diagnosis of the chronic type may not be easy. *Arabell's sign* if obtainable is pathognomonic of the disease. To elicit this sign the observer walks rapidly into the ward and makes a noise like a sister, when, if the reaction be positive, there will first be heard a muffled clatter of china, and then from some totally unexpected quarter (*e.g.*, the kitchen or the linen cupboard), the infected male will emerge with a nonchalant air and will saunter carelessly from the ward. A search for the parasite should at once be made in this part of the ward.

Prognosis.—This is good in chronic cases. The lesions usually clear up at the end of three months, though sometimes they reform in other places when the new appointment has become well established. In the acute cases the prognosis is always serious.

Treatment.—If there is any sign that the patient is about to propose, drastic measures should be resorted to. A surgeon should be called in, and he, with the assistance of the matron, should completely remove the parasite (total nursectomy). After proposal, little can be done. The proposal is always accepted and prognosis gets worse and worse.

Prophylaxis.—Much may be done by increasing the vigilance of the sister *(A. cerulei)*, an organism which is antagonistic to the parasite. Susceptible patients should be removed from possible contagion at such dangerous seasons as Christmas, and should not be allowed to do night rounds.

Complications.—Marriage with causative organism.

Sequelæ.—These need not be described here, as there are already several very excellent text-books written on this aspect of the subject.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

Treatment of Exophthalmic Goitre.

DEAR MR. EDITOR,—I have recently had the opportunity of seeing a considerable number of cases of exophthalmic goitre, both at the Mayo Clinic here, and at the Crile Clinic in Cleveland, where the greater part of the work is concerned with the surgical treatment of this condition, and I thought that a brief account of the views at present held by the American authorities on the subject might interest your readers. They are best dicussed, I think, under the following headings :—

1. Diagnosis.
2. Pre-operative Treatment.
3. Choice of Operation.
4. Post-operative Treatment.
5. Results.

Diagnosis.—It has long been recognised that under the general heading of Graves' disease were included many atypical cases designated by different writers as false goitre, formes fruste, Basedowoid and Basedowized goitre. They formed an ill-defined group, whose underlying pathology had never been made clear.

Plummer, of the Mayo Clinic, basing his views on the clinical findings in a large number of cases, has for some years recognised two seperate and distinct types of hyperthyroidism, each characterised by its own pathological change in the thyroid gland. In the first type the clinical picture is one of true exophthalmic goitre and the gland is found to have undergone the hypertrophy and hyperplasia characteristic of that disease. In the second type the clinical picture is one resembling true exophthalmic goitre, but distinguishable from it, and the gland is found to contain single or multiple adenomata. In a very small number of cases both of these changes may be found together.

The following are the chief points in the differentiation of thyro-toxic adenoma :—

1. Enlargement of the gland was noticed on the average 5 to 10 years earlier in life, by patients with adenoma, than by patients with exophthalmic goitre.

2. In exophthalmic goitre the symptoms of hyperthyroidism followed the goitre within the first year of its appearance; while in the case of the patient with thyro-toxic adenoma on the average fourteen and a half years elapsed from the appearance of the goitre to the onset of its symptoms. This disease, therefore, as C. H. Mayo points out, is one of middle life.

3. Exophthalmos is only very exceptionally seen in cases of thyro-toxic adenoma, while in exopthalmic goitre it is relatively common. In a large series of cases of known exophthalmic goitre of two years' history, exophthalmos was present in 87 per cent. It was less frequently present in the early stages of the disease, averaging 50 per cent. in cases of less than three months' duration.

4. The symptoms of thyro-toxic adenoma are, on the whole, less severe than those of exophthalmic goitre, while the gastro-intestinal crises and the cardiac thrills and bruits of that disease are never found in the patient with thyro-toxic adenoma.

In the diagnosis of hyperthyroidism, especially in its early stages, the neurasthenic patient with a simple enlargement of the thyroid gland may, and often does, present great difficulty. I may mention here in passing that endemic goitre is extremely common in this country in the region of the Great Lakes, as may be gathered from the report of an observer who examined recently 1,783 unselected persons in the Lake Superior region of Michigan and found a pathological enlargement of the gland in 1,146. Cases of simple goitre, therefore, with psycho-neurotic manifestations are not uncommon, and it is felt here that the only certain way of excluding these cases from the category of hyperthyroidism is by a consideration of their basal metabolic rate. Such patients occasionally have a rate above normal, most often due to the excitement of the examination, but their basal metabolic rate is never persistently elevated, and it is the opinion here that a normal metabolic rate is never consistent with the diagnosis of hyperthyroidism. It is obvious that these cases of simple goitre, if classified as exophthalmic, may be operated upon with excellent results and improved motality rates.

Goetsch has described a test depending on an increased reaction to adrenalin in cases of toxic goitre. Many patients have a normal metabolic rate and a positive Goetsch test, and most authorities do not regard it as a reliable indication of glandular overactivity. It is generally agreed that the basal metabolic rate is at present the best indication of the presence or absence of hyperthyroidism in cases of doubtful diagnosis, and of its degree and intensity in case of established diagnosis; and its practical appliion has become for the present the most important question under discussion relating to this condition.

Pre-operative Treatment.—Crile insists that in exophthalmic goitre the operation is only part of the treatment, and in his clinic great care is taken in the preparation of the patient and in his after-treatment.

If on admission to the hospital the pulse rate is above 100 per minute, 2 c.c. of Tincture of Digitalis (U.S.P.) are given four-hourly, for 12 or 15 doses, and this is usually sufficient to lower the pulse rate, improve the patient's general condition, and allow a preliminary ligation in the most severe cases.

Crile considers it important that the body should not be deprived too suddenly of its thyroid secretion, and all his patients on the night before operation are given 2 grains of Thyroid Extract, and the dose is repeated on the following morning.

The majority of the patients before operation are given large quantities of saline, and cases of any severity are transfused. It is felt that if, in a severe case, the condition of the patient can be sufficiently improved to allow a successful preliminary ligation, the ultimate result of the case will be satisfactory.

Regarding his low mortality rate—1 per cent. in a series of unselected cases—Crile considers the use of local anæsthesia and analgesia as the most important contributing factor. Local anæsthesia alone, he maintains, subjects the patient to considerable psychical shock, but this may be eliminated and the undoubted advantages of the method retained by using it in conjunction with nitrous oxide analgesia. This combined method of anæsthesia has almost completely displaced the use of general anæsthetics in the Crile clinic.

Choice of Operation.—The only methods to be considered at the present time in the surgical treatment of exophthalmic goitre are :—

1. Injection of the gland with boiling water.
2. Ligation.
3. Thyroidectomy, either partial or complete.

Concerning the use of the first method, there is a good deal of discussion. Porter who first advocated the method says that he has never had a fatality; on the other hand, C. H. Mayo states that he has seen three deaths following its use, and points out that if the water is not sufficiently hot to coagulate the gland substance, it only serves to dilute the thyroid secretion and causes its more rapid absorption. This may account for the fatalities.

Crile does not regard the method with favour and never employs it.

In the Mayo clinic it is used only for cases of the greatest severity where no more extensive or prolonged operative interference could be safely imposed on the patient. In such cases the method is of value in two respects :—

1. It accustoms the patient to operative surroundings and so lessens the psychical shock of any subsequent surgical measure.

2. It gives the surgeon some idea of the patient's reaction to the least severe form of surgical interference, and on this may be based his subsequent treatment of the case.

Ligation.—Most surgeons agree that where there is the slightest doubt as to the propriety of thyroidectomy, a preliminary ligation should be done. Single ligations, with an interval of a week or more between them, are usually preferred to double ligation at one operation. The upper pole is most frequently selected, and I have only on a few occasions seen the inferior pole selected in preference. Most operators prefer to tie the artery in its continuity, but some think that it is better to divide it between two ligatures and so make sure that no vessel of any size has been overlooked.

If the artery, for any reason, cannot be found, it is usual to ligate the upper pole of the gland itself, and a few operators prefer this method as a routine.

The beneficial effects which are evident in the majority of cases within a short time after ligation are generally regarded as due to the consequent diminution in the blood supply of the gland. Crile, however, is of the opinion that they are due to the blocking of the sympathetic by the ligature, but this hardly bears out the experience of most operators, who have long discontinued operations on the sympathetic.

A consideration of the metabolic rate alone will not indicate absolutely the method of treatment to be adopted, but in general if it is high, *i.e.*, +50 per cent. or more, or if there are present signs of great toxicity, as evidenced by a rapid pulse, much loss of weight, or especially marked vaso-motor disturbances, then ligation should be seriously considered. In such cases Crile strongly advocates treatment by progressive stages, ligation of one vessel, ligation of the second vessel, partial thyroidectomy, complete thyroidectomy, operating upon the patient if necessary in bed and allowing intervals of a month or more between them.

Thyroidectomy.—In doing this operation Crile uses an incision which is more transverse, and placed higher in the neck than the more usual collar incision; the infra-hyoid muscles are quickly exposed and after infiltration divided between muscle clamps, including, if necessary for adequate exposure, the sterno-mastoid. I may mention here that it is a surgical principle in the Crile clinic to obtain wide exposure rather by the free division of tissues than by their forcible retraction. The gland is next infiltrated and quickly removed, leaving only the part immediately in front of the parathyroids and recurrent laryngeal nerve. If during operation the pulse

rate rises considerably or the condition of the patient gives rise to any anxiety, all manipulations are immediately stopped and nothing further is done, the wound being lightly packed with gauze soaked in Flavine, 1 in 2,000. Crile considers it important to provide free drainage after removal of the gland and in severe cases leaves the wound completely open for 24 hours with a Flavine pack. Michel clips are used in all wounds, and are removed on the third day. The operation is usually completed in fifteen minutes, and its notable features are the speed of the operator and his delicate manipulation of the tissues, his attitude, I think, being summarised in the remark frequently made to his audience, "Remember we are operating on the patient and not on the goitre."

Regarding the treatment of thyro-toxic adenoma, if the adenoma is small it is sufficient to enucleate it. If the adenoma, however, is large, or an adenomatous mass is found, thyroidectomy should be done. Ligation in this type of hyperthyroidism is useless.

In the enucleation of an adenoma Crile strongly deprecates the usual method of "shelling it out" with the finger, and the use of blunt dissection. This procedure he considers unavoidably traumatises the trachea and surrounding structures, and for this reason he has entirely discarded it, preferring knife dissection and clean incision of the tissues.

Post-Operative Treatment.—Digitalis is frequently used, especially in those cases in which it was given before operation to reduce the pulse rate, and it is usual to give intramuscular injections of Digital in gr. 1/25, hourly for six doses.

Nearly all the patients are given large quantities of saline after operation, and cases of any severity are transfused routinely.

Regarding acute post-operative hyperthyroidism, Crile is of the opinion that the fatal consequences of this condition are due to excessive chemical activity. It is known that for each degree of rise in temperature, the chemical activity of the body is increased by 10 per cent., that is, if the temperature of a patient rises to 106°, his metabolism has increased 70 per cent. The converse of this is also true. In these cases the immediate need of the patient is reduction of the temperature, and for this purpose the ice pack is used. The patient is wrapped in a rubber blanket and surrounded and covered with broken ice, and an electric fan used to promote evaporation. This method of treatment has been found very efficacious and highly satisfactory. In one case the temperature after operation rose to 106°, the pulse rate was 200, the patient delirious, and his condition critical. Two hours after the application of the ice pack, the temperature had fallen to 99·2°, the pulse rate was 140, the patient was conscious and on the road to recovery.

Results.—In thyro-toxic adenoma, C. H. Mayo states that the average basal metabolic rate following removal of the adenoma falls from +35 per cent. to +7 per cent., usually within two weeks of the operation; this rapid drop in metabolism is in marked contrast with the result from thyroidectomy in cases of exophthalmic goitre with an average rate of +36 per cent. before operation; in these the rate became normal within two weeks, in only 45 per cent., although it was below +14 per cent. in 76 per cent.

Regarding exophthalmic goitre, it is the opinion here that while a small number of cases spontaneously recover, and some are relieved by conservative treatment, thyroidectomy cures about 70 per cent., and improves many others.—I am, yours, etc.,

Rochester, Minn., U.S.A.
July 30th, 1921.

GRANT MASSIE.

Rugby Football.

DEAR SIR,—In the last issue of the GAZETTE, a suggestion was put forward in Passim that the accommodation for spectators at the Rugger matches, during the coming season, should be greatly increased by tiers of duck-boards placed on the opposite side of the ground to that on which the stands are situated.

This is admittedly an excellent idea so far as Rugby is concerned, and should receive the serious consideration of the Clubs' Union Council, when expert advice has been obtained as to the best methods of applying this tier theory, and the extent to which such a temporary stand (or "tanner bank," as it is known in South Wales) would damage the field near the cricket pitch.

This scheme was put into practice in a very small way either in 1912 or 1913, and is therefore by no means a new idea. It was, however, abandoned because these duck boards were too heavy for one groundsman to be continually moving about. And if they were left in one place throughout the winter, the grass would have ceased to exist long before the cricket season was thought about. The old scheme seems to be far more economical than that devised by you in the last Passim, as the necessary difference in the height of the rows was obtained simply by adding six-inch blocks of wood under the existing type of duck-boards. Why not extend this scheme by adding a block one foot thick to the third row of boards? Now that we have an assistant groundsman it is quite possible that, if the scheme is tried in this extended form this season, it will not be doomed to failure on the same score as the 1912 or 1913 effort.

The question of rope seats has been gone into, and you will be interested to know that 400 people could be thus seated round the ground on surplus army benches suitably adapted to prevent their sinking in the wet ground; and that estimates for these have been obtained.

Your statement that the stand has been enlarged does not describe the improvements which have been made.

A large and entirely new grand stand has been erected at considerable cost.

You complain that it was almost impossible to see the games, last season, when arriving a quarter of an hour before the commencement of matches (or rather the advertised time for kick-off.)

It is to be hoped that, in the coming season, those who were so unfortunate during the past, one will avail themselves of the opportunity of booking some of the 200 odd seats which are being set aside for members. Another 200 or more will be similarly reserved for the public, while the remainder of the 850 seats will be saleable on the day of the match.—Yours, etc.,

S. P. MEACOCK.

DEAR SIR,—In reading the last issue of the GAZETTE I noticed some notes in your columns dealing with the Rugger team. I must say I think your suggestion of foot-boards a splendid one. I am enclosing a chart of last season's matches, which will possibly interest you. I trust this coming season will be as good. Such a good team, who play good football, should be well supported. I hope myself to see all the matches.—I am, yours truly,

An Old Guy's Man and Rugger Fiend,

C. HOLLOWAY.

100, Elliscombe Road,
Old Charlton, S.E. 7.
August 8th, 1921.

DEAR SIR,—The following was told me by a Potential Out-Patient. It's yours to do what you like with :—

"Me Sister's gal was with a lidy. You know. Doin for 'er like. She was a very good lidy and she put a glass of milk out for 'er every night. Well she used 'ter swaller it like, in the dark in a manner o' speakin' without turnin' the light on as you might say.

One night after taking the milk she ad a 'norful pain and come all chokey like and woke the lidy who, seein' 'er so bad sent 'er to 'Orspital in a 'Amulance. When she got there they put 'er under the X Rays and the Doctor said she'd swallowed a female cockroach in the milk and that the X Rays showed (!) that the beetle had laid millions and millions of eggs, and that they could'nt do anything (!!) because this was such a terrible condition and so infects his (!!) So in dispair they wrote Home Secretary (!!!!) who wrote back to say they'd better give 'er a' overdose o' poison and do 'er in!"

"Yus it's true it's the tale all over the Birbeck!" (a Dulwich pub, and neighbourhood where my informer lives).

I can vouch for this being exactly as it was told me Perhaps they do these things at other Hospitals.—Yours truly,

GERALD B. KIRKLAND.

30th August, 1921.

DEAR SIR,—I trust I shall not be trespassing too far upon your courtesy in asking you to publish a brief complaint. Would it not be possible to provide residents in the College with a key for the gate by the Memorial which opens into Maze Pond? Anyone who lives in the College, and wishes to visit the wards after 5 p.m., is obliged to traverse a noisome corridor, bounded at either end by the most inconvenient steps imaginable. During his passage through this subterranean tunnel, his nostrils are assailed by a horrible odour, while cockroaches and other insects drop upon him as he hurries along.

It is not that we complain of an evil which cannot be removed. The remedy is obvious and simple. Give us keys, and we shall be able to pursue our lawful avocations without fear of molestation either to our nostrils or our pates. -Yours, etc. FED-UP.

Pass List.

University of London.

SECOND EXAMINATIONS FOR MEDICAL DEGREES.

July, 1921. Part I.

S. Berman	J. N. D. O'Rafferty
E. W. Bostock	James Sellick
Roger N. Brandwood	H. H. Steadman
H. N. Collier	S. V. Strong
A. A. Dalby	J. D. S. Thomas
D. F. Durwood	*L. A. S. Trott
C. H. Highfield	C. L. Worthington
I. R. Hill	

*Awarded mark of distinction.

FIRST EXAMINATION FOR MEDICAL DEGREES.

C. E. Allen	Wm. Leslie
E. H. J. Berry	F. J. Mayne
D. E. M. Ettles	W. D. Sheldrake

Conjoint Board.

FINAL EXAMINATION, JULY, 1921.

Medicine.

N. A. Aienger	*M. Hall
S. Annecke	*M. H. Mackeith
M. I. Ahmed	E. H. Richards
A. H. Douthwaite	F. L. Rayner

Surgery.

*M. H. Mackeith	*A. Robertson
*R. J. Hodgkinson	*J. E. Wright
*L. K. Watson	I. B. McCann
*A. H. Shelswell	H. O. Eksteen
*L. R. A. Wells.	

Midwifery.

W. R. Carling	E. H. Richards
H. O. Eksteen	H, B. Jones
S. Annecke	A. T. Rogers
M. I. Ahmed	M. A. El Biblawi
A. H. Douthwaite	E. H. Griffin
*M. H. Mackeith	

* Have now completed the examination.

2ND EXAMINATION, JULY, 1921.

Part 1.—*Anatomy and Physiology.*

I. M. Hurwitz	E. J. Liberman
I. R. Vermooter	P. G. Trafford
S. A. Leader	J. H. Broadhead
O. F. A. Krause	L. E. Owen
A. Canard	H. Maclachlan
F. Martin	W. H. Bradfield
W. F. Payne	G. C. Hughes
D. S. Todd-White	E. N. C. Annis
J. N. Human	

Part. II—*Pharmacology.*

C. A. Marais	J. K. Milward
H. B. Jones	A. F. Percy
B. Kessel	H. Richards
R. J. Hooker	J. A. F. Denyssen
J. A. A.Mekelburg	R H, Amm
H. E. Lewis	A. M. Mishad
J. H. Sullaiman	

FIRST EXAMINATION CHEMISTRY, PHYSICS & BIOLOGY.

Chemistry.

H. T. Rylance	H. D. Kendrick
H. G. Davies	A. F. King
H. Levit	H. Myers
H. W. Lewis-Phillips	A. Outram
H. P. Yew	W. D. Pitt-Payne
J. R. W. Richardson	H. H. Revill
J. E. Piercy	A. W. Reynolds
W. J. Barnard	G. F. Swales
H. G. Brookes	G. T. Thompson
C. E. Bowen	O. J. Sidi
J. D. Cambrook	D. E. C. Robertson
D. Davies	A. Perkins
G. W. Dibble	H. A. Mortimore
I. G. A. Emberson	P. S. Clarence
E. C. Grant	A. E. Nelson
R. H. Hancock	H. Belcher

Physics.

H. G. Davies	A. S. Levy
L. P. Gregory	H. Myers
H. W. Lewis-Phillips	W. D. Pitt-Payne
B. Horwitz	H. H. Revill
R. Franklin	G. F. Swales
J. P. L. Davies	G. T. Thompson
W. J. Barnard	J. G. Van Schalkwijk
J. A. Barlow	G. V. L. Williams
J. D. Cambrook	O. J. Sidi
D. Davies	W. P. Beresford
G. W. Dibble	E. J. Clother
I. G. A. Emberson	E. Greco
E. C. Grant	A. A. Danino
R. H. Hancock	F. R. Taylor
H. D. Kendrick	E. Crocker
A. F. King	H. Belcher

Biology.

B. Horwitz	N. M. Holloway
L. M. Cartwright	G. A. Lawson-Brown
G. C. T. Tregarthen	W. B. Norcott

THE EDITOR will, at all times, be glad to consider articles or sketches, provided that they are accompanied by the writer's name and address, not necessarily for publication. The payment that the GAZETTE *can offer is merely nominal. Authors who desire reprints of their papers should make their own arrangements with the printers when they return their proofs. All contributions to be addressed to the Editor, "Guy's Hospital Gazette," Guy's Hospital, London, S.E.*

Reviews.

Diseases of the Nervous System. By H. Campbell Thomson, M.D. (Lond.), F.R.C.P. Third edition, 1921. (Cassell & Co.) Price 15/- net.

The war did much to improve our understanding of nervous diseases, both functional and organic. This being so, it is obvious that before a new edition of a pre-war text-book can be issued there is much work of revision to be done. This work has been amply and well done in the new edition of Campbell Thompson's "Diseases of the Nervous System."

The old text has been revised in the light of the new knowledge, and additional sections have been added (for example there is now a section dealing with encephalitis lethargica). The book easily retains its reputation for being one of the best of the smaller text-books on nervous diseases.

Aids to Operative Surgery. By H. C. Owin, O.B.E., F.R.C.S. Ed. (Balliere, Tindall & Cox.) 1921. Price, 6/- net.

The latest addition to the well-known "Aids" series, is a small book on operative surgery. It gives short descriptions of most of the operations performed in surgery and in gynæcology. The book is not illustrated, and no attempt is made to go fully into the indications for operation or alternative treatment in each of the given pathological conditions. It is intended to supply a short account of operative surgery which can be easily revised before an examination, and should supplement and not supplant the larger text-books.

The Spleen and some of its Diseases. By Sir Berkeley Moynihan. (John Wright & Sons, Ltd., Bristol.) 1/- net.

Of late years, many conditions associated with splenic abnormalities and especially with splenomegaly, have come to be within the province of the surgeon, instead of being regarded as "purely" medical. Such is the sufficient reason for this book, which contains an amplification of the Bradshaw lecture recently delivered by the author. Not only have the indications for, and results of, surgical intervention under these circumstances been collected in an easily accessible form with adequate references, but the volume has been rounded off by a summary of the history of splenic surgery, and a consideration of the essential pathology of the various conditions.

It is in this last particular that Sir Berkeley Moynihan has laid us under the chief obligation; to a wide operative experience, and to laboratory facilities possessed by too few he has added clearly, if somewhat dogmatically, expressed opinions on the theoretical side, and the original diagrams with which the book is provided, help in the formation of a clear mental picture of the morbid processes at work.

The Rat, and How to Kill Him. By Alfred E. Moore (Founder and Hon. Sec. Vermin Repression Society). (Published by John Bale, Sons & Danielsson, Ltd.). Price, 6d. net.

This little pamphlet is more or less a work of a propagandist character, and the reviewer must confess that he began to read it without any real enthusiasm for the cause so ably championed in its pages. Nearly all works of this sort are apt to be looked upon askance by the average person, as expressing the views of cranks, and as representing "stunts" organised by single-minded, but rather biassed enthusiasts. But even if one approaches the task of reviewing it in this frame of mind, on dipping into its pages one soon becomes interested.

The means adopted for the suppression of the vermin are indeed admirably conceived. The sentence which really attracted the reviewer's attention was one to the effect that the entomologist employed in investigating the habits of the rat, during the anti-rat campaign of 1901 in San Francisco, had the pleasing task of identifying about 10,000 fleas, obtained from the skins of killed rats!

The reports of cases of rat-bite fever in the medical press, including some cases recently reported in the GAZETTE, add interest to this subject.

Besides conveying this disease, it is almost conclusively proved that rats spread plague by conveying fleas from rat to rat, and so to man. Most text-books of medicine mention this point.

Other rat-borne diseases mentioned in the pamphlet are Trichinosis and Spirochætal Jaundice. The implied suggestion that rats convey cancer is not supported by evidence, and the matter must be regarded as being *sub judice*, until this evidence is forthcoming.

The author deals in detail with methods of killing rats, and seems to oppose the use of rat-virus, which he does not consider to be innocuous to man.

The rat has certainly outlived his use as a scavenger, and it is perhaps no exaggeration to say that the extermination of these vermin will form a very important part of Public Health measures in the future.

Meanwhile we wish more power to the elbows of our modern Pied Pipers.

The Clinical Examination of the Nervous System. By G. H. Monrad-Krohn, M.D. (Christiana), M.R.C.P., M.R.C.S. (Lewis & Co.,) 1921. Price 6/-

This small book was written to provide the student with a convenient and comprehensive scheme for the examination of the nervous system. When one begins first to study the central nervous system in disease, one flounders helplessly in a sea of apparently discordant signs and symptoms. One is never sure that everything has been done and that one has not left some all-important investigation undone. So some such scheme as that which Dr. Monrad Krohn sets out here has long been needed. The student who learns and follows this system will gain both time and confidence, and will later be able to turn to other books where the signs are correlated.

Dr. Monrad Krohn is to be congratulated upon the excellence of this small book which he has written in what is to him a foreign tongue.

The Hockey Club.

The general annual meeting was held on June 23rd, the President being in the chair. It was decided to approach the hockey clubs of other hospitals with a view to inaugurating a second eleven cup competition during the coming season. Owing to their unpopularity last season, it was decided to defer, for the time being, the arrangements of any "A" team fixtures, and also that the election of the Captain of the second team should be elected by the second team when that was constituted. The Forest Hill Cricket Club ground was re-rented for next season. The Club is unfortunate in losing several of its members including S. C. Olver, whose tragic death will be a great loss to the club and a great grief to his friends; and B. M. Tonkin, last season's captain, who has returned to Natal.

Several new fixtures with Units of the Army have been arranged, and it is hoped to make annual fixtures with Balliol College, Oxford, and Christ's College, Cambridge. Five members of the Guy's team were also members of the United Hospital's team, and three others played at times.

The following officers were elected for the coming season:—

President.—F. J. Steward, Esq., M.S.

Vice-Presidents.—C. H. Fagge, Esq., M.S., A. W. Ormond, Esq., F.R.C.S., E. C. Hughes, Esq., O.B.E., M.S., L. Bromley, Esq., M.Ch., all re-elected.

Captain.—L. E. Owen.

Vice-Captain.—J. W. Schollum.

Hon. Sec. and Treasurer.—F. E. Graham-Bonnalie.

Committee.—C. G. Bowen, W. S. Hunt, H. Slater, E. C. Smallbone, I. P. Spurrell.

Blues were awarded to—Messrs. L. E. Owen, W. S. Hunt and F. E. Graham-Bonnalie.

Half-Blues to—C. V. Baugh, H. Slater and K. Hooper

Football.

Rugby Club.

Fixtures have been arranged with the following Clubs for the ensuing season:—

HOME.	AWAY.
Bristol.	Aberdeen *
Coventry.	Bristol.
Cambridge University.	Blackheath.
Devonport U. Services.	Catford Bridge.
Gloucester.	Coventry.
London Scottish.	Cambridge University.
Oxford University.	Cardiff.
Old M. T's.	Devonport U. Services.
Old Alleynians.	Gloucester.
Plymouth Albion.	Harlequins.
Richmond.	Mæsteg *
R. A. F.	Neath *
Rosslyn Park.	Northampton.
Swansea.	Old Leysians.
	Old Blues.
	Plymouth Albion.
	Swansea.
	United Services.

* Easter Tour.

Fixture cards are in course of preparation and may be obtained from the Hon. Sec., R.F.C., when ready.

Specialities.

HORLICK'S MALTED MILK CO., LTD., SLOUGH, BUCKS, ENG.

It is now many years since the founder of this Company conceived the idea of blending full-cream milk with cereals so as to form a perfect food, and although the success of this enterprise has initiated many imitators, yet Horlick's Malted Milk to-day still leads the way, and was never more widely appreciated.

The absolute confidence which this food preparation enjoys throughout the medical and nursing professions, whether as an ideal food for infants, or as a nourishing diet for invalids, is well merited, for its analysis shows it to be an extremely "well-balanced" food, prepared under the finest hygienic conditions.

It will be found most serviceable in an endless variety of cases, and not less so as a shadow food in which to administer the carbonate of bismuth or sulphate of barium for X-ray purposes.

Deaths.

STEINBACH.—On August 26th, at Newton House, Knaresborough, Edith Croft (*née* Goodison, M.B., B.S. Lond.), the beloved wife of Horace Steinbach.

CROSS.—On July 31st, at the Wood Hut, Fylingdales, Robin Hood's Bay, Euphemia Patricia MacKay Smith, late Sister Accident, Guy's Hospital (1879), beloved wife of T. B. Cross, M.R.C.P. Eng. (retired), of Scarborough and Fylingdales.

ED.—A. T. R.

GUY'S HOSPITAL GAZETTE.

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Passim.

DURING the past fortnight, a further example of the mistaken policy of the present Government has come to light. For the last two years, the London boroughs, through their infant welfare centres, have been supplying poor nursing mothers with milk and other goods, free of charge. This scheme has met with universal praise; it has worked well and has been a boon both to the patient and to her doctor. The patient was usually thankful for this bounty and glad to avail herself of it, while the doctor was able to rest assured that his patient was receiving an adequate amount of good food at a time when she needed it most.

The cost of the scheme has, in the past, been equally shared by the borough and by the Ministry of Health. Now the Ministry of Health has sent a circular to the borough welfare centres urging economy in the distribution of milk, and announcing that they will hold themselves responsible for only five per cent. of the cost of the milk, instead of their customary 50 per cent. Coming at this time, such a decision is an act of criminal folly. Never have we needed the measure more than we do now. Unemployment is everywhere in the poorer boroughs. Mothers, who, in better days, would prefer to remain independent of state support, now find that they are not able to afford all their extra needs, and they turn to the welfare centres for help. Are we to refuse them this help? Surely, for the sake of a few paltry thousands in our yearly expenditure of millions, we are not going to sacrifice the health of these mothers or the lives of their children!

If the Ministry of Health were to do right, it would not cut down its milk supply in this way, but it would enlarge and extend this supply, so that clean milk might be available at a small cost to every poor family. During the last few weeks we have been faced with an unusually severe epidemic of infantile summer diarrhœa. Each week has brought its tale of a higher and higher loss of infants' lives, and we have stood by unable to stop the spread of the dread malady. The part that infected milk plays in the epidemic is yet to be determined; but it is agreed that the disease could kept within bounds, if not entirely prevented, if we were able to adopt sufficiently energetic measures, one of the first of which should be the establishment of a clean milk service.

But no! the Ministry of Health is actuated by the cry of economy which at present pervades all political circles. Anti-waste is the slogan of the day, shouted at every street corner by every Parliamentary candidate, and spread by the Press to the ends of the land. But even the

most earnest (we had almost said the most rabid) advocate of anti-waste, would not countenance this ruthlessly reckless and indiscriminate economy, which Sir Alfred Mond proposes. Money spent on the health of the nation is not money wasted. It will be repaid with generous interest in the years to come.

The full absurdity of Sir Alfred Mond's action is simply, yet forcibly, brought out in the excellent cartoon, which we publish on this page. This cartoon was drawn for "The Star" by their talented cartoonist, Mr. David Low, and we are indebted to the Editor of "The Star" for permission to republish it in the GAZETTE.

THE TROPHY.

[Sir Alfred Mond is making heavy cuts in the Ministry of Health's grants to municipalities for milk supplied to poor nursing mothers and babies.] [*From the "Star."*

It seems that the Ministry first proposed their foolish scheme about six months ago. Some of the welfare centres were being run by newly qualified practitioners, who, in the opinion of the Ministry, were distributing largesse with a too ready hand. In consequence, the Ministry decided to withdraw their support and to place the whole cost of the scheme upon the shoulders of the Borough Councils. Representations against this were at once made, and the Ministry altered their decision and offered a beggarly 5 per cent. By doing this they have done nothing to alter the state of affairs which they resented, and they have penalised the unoffending centres equally with those that were extravagant.

There might have been some justification for the Ministry, had they decided to set a definite limit to the amount which they would give to each borough—an amount which would have been regulated by the borough's need. This would have had as much, if not more, effect upon the extravagance of the offenders, and would not have involved any sacrifice on the part of those boroughs that were already hard pressed fully to satisfy the demands which were being made upon them. It would at least have been preferable to the present unwarrantable measure of false economy

---

ON September 1st, the new Dangerous Drugs Act came into force. This law, passed with the view of limiting the opportunities of drug-maniacs, places restrictions on the sale of such drugs as morphia and cocaine. Hospitals and Infirmaries are, however, not subjected to the full stringency of the act, provided that their drugs are dispensed by a doctor or pharmacist, and provided also that certain conditions are observed.

Supplies can only be obtained on the signed order of a medical officer or pharmacist. Thus any house officer who now wishes to give a patient any one of the prescribed drugs must sign his order on the bed-letter, and if a further dose is needed he must rewrite and sign his prescription. A record is kept of all such drugs dispensed and must not be destroyed for two years. The sister of a ward may keep a locked supply which can only be used by the direction of a medical officer. Steps have to be taken, too,

to prevent any theft of drugs during their transit from dispensary to the wards.

Thus are we hedged round with regulations and red tape, and yet, now that we are settling down into the new routine, we find that these drugs are, if anything, more easily obtainable now than they were before the passing of the act.

A short article which is written to give a brief explanation of the Act to old Guy's men in practice, has been written for us by Mr. Williamson, the chief dispenser to the Hospital, and appears on page 378.

WE have received a prospectus from the National Hospital for the Paralysed and Epileptic, Queen Square, announcing a post-graduate course of lectures and demonstrations on Neurology, to be held there during the next three months. Particulars of the course may be obtained from the Dean of the Medical School, Queen Square.

THE subject for the Treasurer's Prize Essay of the Physical Society for the coming session is "The Transplantation of Living Tissues for Remedial Purposes."

A SECOND letter from America from Mr. Massie appears in this issue, and deals with the subject of peptic ulcer. We are promised a third on neurological surgery.

THE "spoof" article on Nursosis, which we had the temerity to publish last week, has, we find, stirred up anger in the hearts of many of our readers on both sides of the hospital. One passage which seems to have been especially resented, is that where our contributor announced that "The proposal is always accepted . . . . ." This we had ourself thought both unkind and unwarranted, when we were revising the manuscript for publication. We had almost deleted it, when we reflected that we had no authority so to do. (For we are glad to be able truthfully to say that we have never suffered from the acute form of the disease which our contributor describes). So it seemed to us that we, in our ignorance, could not dare to erase any remark made by one who was so obviously well-versed in his subject; and we let the passage stand. Hardly, however, had it appeared in print, than we were approached silently, almost surreptitiously, by several men each of whom in turn took us aside and told us, that, much as they appreciated the article, there was one serious mistake in it, which our editorial blue pencil should never have let pass. Thus it is that we can now assure our readers (confidentially and in a low voice) that—proposals are *not* always accepted.—We rejoice and we offer our sincere apologies to those whose feelings we have hurt and we trust that they may be more successful when next they go a-wooing.

We regret that we are not able to publish the apologies of the writer of the article. We sent on the glad news to him and invited him to make the *amende honorable*, but he remains obdurate, and in answer to our request has sent back the terse and unrepentant letter which we publish among our correspondence.

Several counter-thrusts at this ribald writer have been sent to us; and we would, we believe, have received more, were it not for the wholesome fear in which the printer is held by the nurses. Some of our correspondents contented themselves with prose; others in a more daring mood essayed verse. Without wishing to appear at all invidious we must say that we preferred the prose, the cleverest of which appears on page 371. The writer of this accuses Mr. A. B. Rowser of suffering from an affection known as

"tête gonflée," which, we are assured on creditable authority, comes to the same thing in the end as swollen head.

We, however, do not endorse our correspondent's invitation to Mr. Rowser to offer himself as a pathological specimen. We would hate to see Mr. Rowser's cheerful face grinning at us from inside a bottle in the Museum; and we trust that he may long be spared to grace our pages with his witty articles.

The 1918 Influenza Epidemics in a German Prisoners of War Camp.

BY FRANCIS HEATHERLEY, M.B., B.S. Lond., F.R.C.S. Eng.
Cardiologist to the Ministry of Pensions.

The camp was formed during the early days of the war by taking over some weaving sheds which had just been built and which made a series of fine lofty dormitories.

I was in medical charge from the beginning of January, 1918, until the camp was dissolved in June, 1919; during that time it contained between 1,400 and 1,500 prisoners, and a British guard of about 200.

During 1918 there were two epidemics of Influenza, one in June and the other in November, which affected both the guard and the prisoners, but as the disease was much milder amongst the guard I shall confine my remarks mainly to the prisoners.

When the epidemic began I cleared the dormitory, which from its position could most easily be isolated, and which on the 40 square foot scale had accommodation for 80 cases, and opened it on June 24th, when I transferred to it the first 10 cases which I had previously housed in a 60 foot army hut used as an isolation ward in normal times.

At the same time I prepared this hut for the reception of pneumonia cases by having all its windows opened wide and screwed tightly in that position.

The June epidemic showed itself first amongst members of a labour gang of about 200 who went daily to to work at some neighbouring steel works, and though my orderlies and myself inspected the men every evening on their return, and gathered in all suspicious cases before they dispersed to their dormitories, the disease spread so rapidly that by the morning of the third day, June 27th, there were over 100 cases in the Isolation Dormitory with many more awaiting admission, so I gave up any further attempt at isolation.

In a typical case the man became prostrate in the course of a few hours. He looked tired and heavy lidded, his conjunctivæ were suffused; he complained of intense headache and pains all over, and he had cold shivers and sore throat.

The fauces were injected and the soft palate was studded with little glistening points which I took to be the ducts of mucous glands, a condition one might call a mucous goose skin.

The suffusion of the conjunctivæ was a very common sign, and led to my orderlies calling the disease Pink Eye.

This "pink eye" was a useful diagnostic sign as it occurred early and was present even in the apyrexial cases.

Although in individual cases temperatures up to 105° were recorded, the majority ran a two day fever with a maximum of 102°.

Twenty per cent. of the cases remained apyrexial throughout and, except for the "pink eye," they reminded me of cases of brisk general reaction after Typhoid inoculation; they seemed to feel quite as ill as those who were feverish.

After I gave up trying to isolate fresh cases I reserved the Isolation Dormitory for cases which I thought required watching.

Any case in the general dormitories with a temperature of over 102° was carried into the Isolation Dormitory and at the same time its population was kept down to about 80 by sending back to their own dormitories all whose temperature had been normal for 24 hours.

Any case in the Isolation Dormitory or one of the six general dormitories which showed blood in the sputum was carried into the Pneumonia Hut.

Charts were only made out for cases in the Pneumonia Hut.

With the frequent transfer of cases it would have been difficult to keep even a rough record but for the systematic methods of my original German orderlies. Each man's name was entered on the left hand page of an army folio book preceded by his number in order of admission, and each case was given four lines including those on the right hand page. At the same time a tear-off gummed label with his admission number was stuck on the bed board at the foot of his bed, so that wherever he was removed to with his bed his case could easily be turned up in the book.

In the Isolation Dormitory all temperatures were recorded morning and evening but in the general dormitories only evening temperatures were taken as a rule because although at the beginning of the epidemic I increased my permanent staff of six R.A.M.C. men and three German Hospital orderlies by making use of twelve prisoners who belonged to the German Medical Service, yet with the exception of my corporal and myself all were bowled over at some time or other; he and I had snivelling colds but no loss of appetite.

I found these men of the Sanitäts Korps of very little use. It would appear that, like our own R.A.M.C. it became during the war a refuge for the unwilling and incompetent.

On the other hand my three hospital orderlies were excellent; they were combatants dating back to the battle of the Marne who, admitted as patients in the early days of the cam p had been found useful and had volunteered for duty. The irony of the situation lay in the fact that they were only entitled to a few pence a day whereas the worthless Sanitäts Korps drew the same pay as our R.A.M.C.

This June epidemic, owing to the dramatic suddenness with which it bowled the men over and the rapidity with which it spread caused great alarm amongst the prisoners.

It ran through the camp like wild fire and reached its height on June 30th and July 1st, on each of which days 150 new cases were recorded, and then declined rapidly. The epidemic practically ceased on July 4th, after which date very few cases were recorded.

Altogether 540 cases occurred, and by the end of the first week cases of influenza were lying about in all the six dormitories.

One of the features of camp life in those days was the procession of orderlies carrying quart glass jugs of chlorine gargle and quinine mixture in the wake of the two orderlies taking and recording temperatures.

As many of the prisoners were of old standing it formed their introduction to the use of chlorine, and evoked many uncomplimentary remarks about German chemists, but it is doubtful which they disliked the more the gargle or what they jokingly called Blue Danube water. However, although the camp was stocked with more drugs than I had previously seen provided for a British brigade, the quinine and hydrochloric acid gave out half way through the epidemic, and when I substituted chlorate of potash gargle and small doses of paregoric they were better pleased and did equally well.

As before mentioned, this epidemic alarmed the prisoners much more than the more virulent epidemic in November, and on such evening rounds some, greatly dreading being ticked off for transfer to the Isolation Dormitory, which they looked upon as a first step towards the mortuary, would endeavour to hide themselves. One incident I remember is of a girlish lad of 18 who got his chum to hide him in a dark corner. When my men found them the chum was bathing the lad's face with cold water, and they made an odd looking couple as the chum wore a ragged black mask to hide the loss of one eye and half his face.

I wanted the prisoners' band to cheer the prisoners by playing to them, but as only the conductor and the big drum were available the project fell through.

This first epidemic was a sort of foretaste of the second with its leading evil characteristics still in embryo. Thus, of the 234 cases transferred to the Isolation Ward only sixteen required cough mixture. There were two cases of epistaxis which at the time were attributed to the use of a very weak spray of formalin used for cases of nasal obstruction. Eight cases had to have hypnotics, and one case had diarrhœa, and one developed general anasarca lasting some days, but without any albuminuria.

Of the six cases transferred to the pneumonia hut, owing to the presence of blood in the sputum, the worst had marked hæmoptysis for the first three days during which his temperature varied from 101° to 104°. It was hæmoptysis indistinguishable from that of phthisis with the inside of the sputum pot covered with scarlet splashes. His pyrexia lasted 19 days with indefinite signs of consolidation and fluid in both lungs about the angle of the scapula.

The only other serious lung case had a 12 days' pyrexia with rusty and afterwards purulent expectoration but no signs of consolidation. In his case the temperature fell from 105° to normal in 36 hours. Both these men had subnormal temperatures for a long time afterwards.

The only fatal case during this epidemic was one of meningitis admitted during one of the last days, when all danger seemed to be over.

I spent much of my time during the epidemic among the prisoners, and it paid me well, as, ever after, what I said was law, and in the general routine after the epidemic had passed away my work in picking out unwilling candidates for labour camps was rendered easier by private information from German headquarters as to probable malingerers.

There is one point about this first epidemic on which I should like to lay stress. I used to think that the terilisation of drinking and eating utensils was an important precaution against the spread of influenza. Yet this epidemic spread like wildfire although each man had his own things which he washed under the tap and dried on his own cloth, so that seemingly there is still something to be said for the old idea of aerial convection as embodied in the name of the disease.

Another point is that although at the height of the epidemic there were men lying ill in all the six general dormitories about 900 prisoners remained well, presumably because they were immune.

What happened to them in the second epidemic I cannot say because the point did not strike me until after all the documents had passed out of my hands, but I do believe that this first epidemic conferred immunity against the more formidable second epidemic because not one of those who figured in the first epidemic was found on the list of the second epidemic although the great majority of them were still in the camp.

The second epidemic began in November, *i.e.*, five months after the first. It was imported by a convoy from a camp in Wales which was being hurriedly cleared o make room for Irish politicals, and in this way the disease was carried to two other camps besides ours. Although all the prisoners declared themselves well on arrival, two were admitted the same evening with temperatures of over 102°.

As after a few days it became evident that we were in for another epidemic and of a severer type than the first, a larger dormitory capable of accommodating 200 men was cleared and opened as an Isolation Dormitory, and

at the same time all transfer of prisoners to and from the camp was stopped.

Although severer in type the second epidemic never reached the dimensions of the first, as in all only 80 cases were admitted, but of these seven died.

I do not attribute this limitation of the epidemic to our measures of isolation but to our immunity, because unlike our experience in the first epidemic none of the nursing staff were affected in the slightest degree, although no preventive measures, *e.g.*, the use of masks or disinfectant gargles, were employed.

Of the seven men who died, three were members of the convoy who introduced the disease, three were convalescent wounded transferred to us in September, and one, although an old resident, was away at a farming camp during the first epidemic. I do not know when these seven last had influenza, but I think the evidence justifies my belief that the June attack immunised us against the November epidemic.

This second epidemic was long drawn out with admissions in driblets, the 80 admissions being spread over 39 days in contrast with over 500 in 11 days in the first epidemic. The virulence of the epidemic was most marked in the first week, during which five of the fatal cases were admitted, and the height of the epidemic was reached on the sixth day when nine cases were admitted, of which two afterwards died. The average stay in hospital was 14 days, but that of the 16 worst cases that did not die works out at 35 days.

As my orderlies soon pointed out to me the suffusion of the conjunctivæ which was such a marked feature of the first epidemic was not noticeable, but if Pink Eye was the appropriate epithet for tho first epidemic, Pink Spit characterised the second; not that it was at all common, but because it was a new and remarkable sight to see two or three men in adjacent beds coughing hard and bringing up nothing but rosy froth.

As in the first epidemic the meningeal cases occurred towards the close, being represented in this epidemic by a fatal case of meningitis and a typical case of encephalitis lethargica; as the latter was transferred to another hospital I do not know the result. "Pink Spit" was recorded in 16 cases, *i.e.*, in 20 per cent. of the whole.

It was closely associated with general cyanosis of the body as out of twelve cases of general cyanosis nine are recorded as having this sign. I have no clear recollection of two of the exceptions but the third became delirious quite early, had delusions about poisoning and swallowed all his expectoration.

Cyanosis occurred in six of the seven fatal cases, the exception being the fatal case of meningitis.

General cyanosis was the most fatal sign for of the twelve who showed it six died.

Of these twelve cases of cyanosis three underwent a further change, the cyanosis gradually becoming concentrated in the lips and ears which assumed a dark purple colour.

This was even a more fatal sign as of the three who developed it only one recovered. He, a lad of 20, was a most unpromising case as when admitted he was only just convalescent from penetrating gunshot wounds of the chest and abdomen. He ran a temperature of 104° for the first four days; by the third day he was delirious, had oedema of both bases and was spitting quantities of pink froth, stupor and marked deafness supervened and by the sixth day the inside of his mouth was covered with sordes. He lay with his mouth open and black lips and ears for several days, on each of which he was expected to die and then gradually he began to improve.

The most rapidly fatal case was a lad aged 23 who was found at Sick Parade to have a temperature of 104°. On admission he had slight oedema at the right base and his pulse rates lying and sitting were 112 and 134. His lung trouble did not spread but on the second day he was deaf and stupid, becoming delirious about mid-day although his temperature had fallen to 102°. On the third day his temperature rose to 104° and slight general cyanosis was noticed. This was the first occurrence of cyanosis in the epidemic and as it was put down to heart failure he was ordered 1 oz. of brandy every four hours when I saw him in the morning, and as that had no effect it was ordered every two hours in the afternoon. The temperature remained at 104° until his death at 6.30 a.m. on the fourth day of his illness.

The onset of cyanosis was insidious and generally first noticed on the third day. The colour has been aptly described as heliotrope or lilac. When I first noticed it I was much tempted to try venesection as I had seen good effects from this treatment in cases of distress after a heavy meal in mitral stenosis but as there was no dyspnoea I fortunately changed my mind.

With the exception of a man aged 40 all the fatal cases were under 25.

The symptoms markedly associated with cyanosis were insomnia, delirium, deafness and stupor.

Insomnia occurred early and, although partly due to the harrassing cough, was associated with mental excitement which gradually merged into delirium.

The delirium was quiet and took the form of muttering and picking at the bed clothes.

Deafness was both common and marked. I do not think that it was due to the quinine, which was only given in small doses as a placebo, because it deepened after the quinine was omitted and also occurred in some who had not had quinine, and I do not think it was due to otitis as it was not followed by otorrhœa. I look upon it as part of the process which produced the stupor and mental obscuration.

The stupor was often deeper than it seemed. One man, who recovered, apparently only had it slightly as he could always be roused to answer questions rationally. Yet afterwards he admitted that of three men who died in the bed alongside his he was only aware of the third death. He was one of the six cases of general cyanosis who recovered.

On the whole I think the stupor was a merciful dispensation. At one time I thought it hastened death by interfering, like an opiate, with expectoration, but in

the two fatal cases in which stupor was absent the only difference its absence made was that the patients suffered a great deal from acute dyspnœa and seemed conscious of their approaching end. Both were examples of the severe type of cyanosis in that their lips and ears were a deep purple, both died drowned in their expectoration, and one of them, the man of 40, took the record for profuse expectoration, his sputum pot having to be emptied eight or nine times in the 24 hours.

In one case stupor seemed rather helpful. He was a well educated rather neurotic individual, a science teacher in a college, who was terribly upset when admitted at a time when a funeral was of almost daily occurrence. He became still more anxious when he started coughing up quantities of pink sputum, but later on when cyanosis supervened and he became deaf he became more content, used to smile fatuously and agreed that he felt better when I shouted encouraging opinions I was far from feeling, as the whole of the inside of his mouth was caked with sordes, and then he would take his nourishment and go to sleep.

I omitted to keep a record of the number of cases which had epistaxis so can only say that it was common, in some cases severe, even alarming in amount and recurring during several days.

When the Aldershot results were published early in January, recording albuminuria being very common in British cases, I was sorry I had not made routine examinations of the urine. By this time nearly all my cases were convalescent, but none of about a dozen cases showed any trace of albumen. It must, however, not be forgotten that the two dietaries differed considerably, the Germans were even more strictly vegetarian than they need have been because they shared the British prejudice against horse meat which was then issued to prisoners.

Some time previously, after reading an article on diffuse seborrhœic dermatitis and its dependence on acidosis in British soldiers, I examined the urine of all my cases as well as of most of the other patients then in hospital and found that alkaline urines were the rule, even faintly acid urine was exceptional.

As regards temperatures, in this epidemic no apyrexial cases were noted. All charts showed as sudden a rise as in the first epidemic, but in the majority the temperature went higher and stayed high longer, a temperature of 104° day and night for several days was common.

As noted by the Aldershot observers the charts were no help in prognosis. For instance in the case of one man the temperature fell gradually from 104° on the evening of the 8th day to 97.4° on the evening of the 10th day, but yet he died next morning at 4.30 a.m.

In several cases the temperature after falling to normal about the 9th day rose after a few hours for a relapse lasting about a week. Three of the cases attributed the relapse themselves to smoking German cigarettes.

In these relapses there was abundant purulent expectoration and the chart was of an oscillating hectic type.

Persistent subnormal temperatures for long after recovery were the rule: for how long I cannot say, but several isolated observations showed the condition existing three weeks after discharge. As far as my observation went this led to no harm.

The earliest physical sign in the lungs was that of localised œdema, as shown by fine crepitations: just the silky rustling one hears over the bases of the lungs in valvular disease with heart failure.

In two of these cases it temporarily disappeared after two or three deep breaths, just as in a heart case. I therefore, as part of the treatment, encouraged them to sit up two or three times a day and take a few deep breaths, and also made it a rule to auscultate each case sitting up twice a day whilst an assistant recorded the difference between the pulse lying and sitting.

As regards the usual site for the appearance of this sign, all parts of the lung were recorded at various times except the axilla. In order of frequency the sites were: right base, left base, both bases, left apex and right apex.

The three cases in which both bases were affected simultaneously all recovered, thus falsifying my prognosis.

In some cases, after appearing in the right base, the left would be affected next day, and then after a few days the left base would be clear before the right.

Sometimes a localised patch of œdema would be the only physical sign irrespective of whether the man died or recovered, in others rhonchi, coarse râles and signs of consolidation with or without fluid were superadded.

Twenty-five cases showed this sign, which was accompanied by a hacking cough, and in the majority was succeeded after a few hours by expectoration of the rosy froth.

Besides the before-mentioned sixteen cases of "pink spit" there were three cases of ordinary hæmoptysis. These three never developed cyanosis.

If I remember rightly the Aldershot observers attributed the general cyanosis to the exudation of an albuminous membrane in the alveoli which mechanically interfered with the interchange of oxygen.

I think that if this theory were correct the blood after passing through the obstruction should have become bright. Yet the blood spat up, thoroughly mixed with air, formed a cyanosed pink froth showing, I think, that the colour was due to a blood change.

It would have been interesting to have studied the colour of thin films of the blood in epistaxis, but the point did not strike me till too late.

Sequelæ both in the first and second epidemics were rare, especially so as regards the heart, as in the second epidemic there were three cases of bradycardia and one of tachycardia.

This was a great contrast to the British Guard who had 50 cases, all mild, with no cyanosis and no serious lung complications, yet 19 of them on discharge from hospital showed tachycardia, varying from over 100 to over 140. Of these 19 I readmitted the twelve worst in order to record their pulse rates during sleep and in all in which the observation succeeded the pulse was found

to be normal, even in the man with a rate of 144 the sleeping rate was 76.

The average age of the guard was 15 years greater than that of the prisoners. I do not know whether the vegetarian diet of the prisoners by affording more material for buffer salts had anything to do with it but I do not remember coming across more than one case of tachycardia amongst the Germans at any time. I do not know if it is a racial difference, although there certainly seems a racial difference as regards physique for the quarterly weighing of all prisoners disclosed the fact that according to our recruiting standards the Germans of the same age and height weighed one stone more than our men, notwithstanding that they were almost entirely dependent on the official dietary which varied according to class from 1,900 to 2,200 calories per diem which is almost the lowest given in Hutchison's tables.

In the three cases of Bradycardia amongst the Germans the Influenza was of a mild type, one case had a minimum rate of 36, in another the minimum was 48, noted on several occasions. In the third, a lad of 18, although the minimum was only 56 the condition lasted the longest.

Six weeks after discharge when his pulse was in the sixties he developed frequent extra systoles, this condition lasting about a week.

I did not notice the Bradycardia until the cases were convalescent, but owing to the plodding unimaginative style in which the German orderlies kept the charts I was enabled to note not only that the temperature was only raised for a few days during which all three had diarrhœa but that the Bradycardia was present from the very beginning. In one case the pulse was only 100 with a temperature of 104·6 on the evening of the second day and 72 next morning with a temperature of 103·4°.

One advantage I enjoyed in this camp was that of watching the continuity of infection, *i.e.*, the whole progress of the epidemics in a fairly large and isolated community.

In my student days the immutability of disease types was an article of faith. What I think marvellous is that the type does not change more rapidly than it does, when you consider what changes a florist can produce in five or six generations, and how soon the same flower degenerates into a weed when left to itself, and the fact that in the case of the germ each generation lasts less than an hour,

In these epidemics it seemed to me that the type changed so that the germs causing the meningeal symptoms persisted and even became more virulent.

These epidemics may be likened to the visits of comets which may either wax or wane during their progress In our case after traversing a war stricken population it waxed and proved a formidable thing on its second visit, but the epidemic probably comes again like a swarm of meteors and is then responsible for the ordinary common cold which does not attract so much attention, and which may not be distinguishable from a cold which is descended from quite a different epidemic and a different association of germs. This may account for some of the failures in inoculation as instanced in a letter lately received from a friend who had been inoculated on my advice a few weeks ago, and who says that he is now laid up with what under other circumstances he would not have been afraid to call mild influenza.

I have made little mention of treatment because what there was was mainly for psychological effect.

I started the epidemic with a prejudice in favour of alcohol; all the cyanosed cases for instance had alcohol, but although in these cases brandy was pushed, in many cases up to one ounce every two hours day and night, neither my assistants nor I thought it made any difference one way or another.

The only medicine which we agreed did some little good was a citric acid mouth wash for cases with sordes. Many of the bad cases had the whole of the inside of the mouth caked brown. Those who could do so were given apples to chew, and this also proved useful.

As regards food, I arranged that the horse meat should be minced and served separately instead of being mixed with the rations of potatoes, cabbage, split peas, etc., and boiled up into the usual stodgy soup. I found a great deal of prejudice against the meat and had to eat it before them to persuade some of them to take it. Besides this, tinned milk, dried eggs and cocoa enabled me to provide porridge and milk puddings, each man being allowed to eat what he liked. It surprised me to see what large quantities oi food many of the pyrexial cases ate and digested, for there were only two cases of resultant meteorism. Only one man took his food very badly, and his was the fatal case with delusions of poisoning. What was not eaten by the bad cases was consumed by the convalescents.

Owing to the large dormitory never being more than a quarter full it way very airy, the only drawback being that owing to the coal shortage and a break-down in the steam-heating the temperature ranged from 40° to 50°, which the convalescents found rather trying.

At first all cases with high temperature were sponged all over every evening and restricted to use of one blanket. Afterwards, realising that I was up against a disease for which I had no cure I came to the conclusion that it would be safer to allow each man to follow his own instincts and just supply him with what he seemed to want, whether it were more blankets or more food, for I had before noticed at times that a patient's instincts may be in advance of the medical knowledge of the day. When you are in a fog and are driving an old horse which has been that way before it is well, although in the position of authority, to let the reins lie loose on his back and trust to his instincts. After all, we are all descendants of individuals who during untold centuries have managed to recover from many such formidable germ invasions, and as the intellect becomes clouded it is likely that instinct resumes its sway.

I have never forgotten Moxon's classical example of the dangers of treatment founded on logical reasoning, however sound, if there happens to be a flaw in the premiss.

She was a gamekeeper's daughter, who not feeling well, went to consult an elderly female friend, who promptly diagnosed the disease as being due to "a rising of the lights," but who very strangely omitted to mention any remedy. As the girl only noticed the omission when nearing home she had to tackle the problem unaided. Being of a logical turn of mind she thought it out during her walk through the woods, and reasoning that this rising of the lights might possibly be obviated by weighing them down with something heavy she acordingly later on in the evening swallowed a handful of shot from her father's bag and so was eventually admitted to Guy's suffering from acute lead poisoning.

At any rate after reading the results of vene sections, saline transfusions, oxygen inhalations and purposely induced coccal abscesses, I was glad that I had held my hand because although they gave no detailed statistics, if I remember rightly, they looked upon cyanosis as an almost fatal sign, remarking that the only bad case of cyanosis which recovered was so bad on admission as to be likely to bring discredit on any form of treatment and so received none.

Although I think I got better results with less trouble by my methods I hope we shall have better means the next time we are afflicted with such a pestilence.

The great desideratum is an efficient serum. Although by the time an autogenous serum had been produced the epidemic would probably have passed away from that district yet it could be sent on to districts in which it afterwards appears.

Interesting Cases in the Wards.

Cases under Dr. Hurst and Dr. Hunt.

Addison 1. Renal tumour.
5. ?Pernicious anæmia.
6. Infective endocarditis.
10. Tabes.
14. Aneurism.
18. Aortic endocarditis.
19. Congenital heart.

Cases under Dr. Fawcett, Dr. Ryle and Dr. Marshall.

Stephen 28. Tuberculous caries with unusual symptoms.
46. Pyloric stenosis.
48. Oesophageal obstruction.

Cases under Dr. Beddard and Dr. Mutch.

Esther 2. Purpura hæmorrhagica.

Cases under Dr. French.

Addison 29. Splenomegaly of unknown origin.

Cases under Mr. Steward and Mr. Fagge.

Lazarus 2. Infantile coxa vara.
6. Fibrocystic disease of upper end of humerus.

Astley Cooper 22. ?Fibrous ostitis of upper end of femur, with pathological fracture

Obituary.

H. E. CUFF, O.B.E., M.D., F.R.C.S.

The sad death of Dr. Cuff, for many years Principal Medical Officer of the Metropolitan Asylums Board, will be a great blow to the many men who knew him. His official position brought him into contact with a great number of medical men, and he was loved and respected by all who knew him.

His death was due to a bathing accident at Burnham Overy, in Norfolk. His two young daughters were seen to be in difficulties in a rough sea, and he went to their assistance. All three were swept away by a strong tidal current and drowned.

Dr. Cuff was 57 years of age. He qualified from Guy's, taking the M.B., B.S., in 1888, and the M.D. in 1891. He obtained the F.R.C.S. Eng. in 1890.

He was an H.P. at Guy's, and was later Resident Medical Officer to the Leeds General Infirmary. His association with the Asylums Board began in 1893. From 1897 to 1905 he was Medical Superintendent of the North-Eastern Fever Hospital.

During the war he was the resident head of the Belgian Refugee Camp at Alexandra Palace. He received the O.B.E. for his good work in this connection.

He was the author of "Lectures on Medicine to Nurses," and part author of a book on practical nursing.

He always took the greatest interest in his Hospital. Quite recently he wrote a letter to the GAZETTE, about the death of Dr. A. S. Taylor, paying tribute to his friend, and now he too has been taken, and Guy's has lost another of her sons. But his memory will long remain with Guy's men.

Pass List.

Conjoint Board.

FIRST EXAMINATION, JULY, 1921.

CHEMISTRY, PHYSICS AND BIOLOGY.

Chemistry.

L. A. Steel.
C. C. White.
J. A. Simons.
W. E. Thomas.
J. C. Fast.
T. H. Pratt.

Physics.

L. A. Steel.
W. E. Thomas.
J. C. Fast.
T. H. Pratt.

Biology.

T. H. Pratt.

Acute Tonsillitis.

With Special Reference to Certain Infectious Diseases.

CLINICAL LECTURE BY MR. T. B. LAYTON.

GENTLEMEN,—For a good description of tonsillitis we have to go back 40 years to the book written by Morell Mackenzie and published in 1880. From this we learn that the disease has a periodic annual variation, being least common in the spring month, rising during the summer until September, whence it falls again during November and December, to reach its minimum in March and April. He also narrowed the more numerous varieties of earlier writers down to two—the follicular and the parenchymatous. He does not mention micro-organisms, but we now know that the disease is due to a disturbed relation of the resistance of the individual to organisms present in the throat. Either the body resistance being lowered organisms living in the throat and producing usually no marked symptoms cause an acute exacerbation of the local inflammatory changes to occur; or a new organism arising in the throat by droplet infection causes a local manifestation to appear if it be virulent enough to cause any injury to the individual. I believe that in the majority of cases the follicular type occurs when the first of these conditions is the cause and that the parenchymatous condition results when the latter is the cause, although I do not deny that the opposite to each may be the case especially that the parenchymatous may be due to an organism already settled in the throat though not in the crypts of the tonsils. The subjective symptoms are the same in each type. Locally, they are a tickling in the throat or a knowledge that the person has a throat which leads to constant swallowing and is followed by soreness passing on to pain on swallowing. This may become so severe as almost to inhibit the act. Generally, they are the symptoms of fever associated with a varying amount of joint pains or more often of pain referred to the bones so that the patient says that "every bone in his body aches" and which is associated with a profound muscular weakness and even wasting. The objective symptoms are a raised temperature which is frequently 103° or 104°F. and may rise to 105°F. the hot dry skin and the white furred tongue of an acute illness and the condition seen on examining the throat which varies with the two types of the diseases.

In the follicular type the symptoms are limited to the tonsillar area and to the surrounding mucous membrane and the intensity of the inflammation in the latter varies directly with its nearness to the tonsils. These are swollen and the amount of swelling varies directly with the severity of the attack. The surface is intensely red, and this varies directly with the pain on swallowing. There is a general hyperactivity of all the glands of the mouth with much formation of mucus so that all the lining of the mouth and pharynx is covered with a tenacious, sticky secretion. On the surface of the tonsils are seen white spots which are formed by the exudation from the follicles of a white secretion which gives its name to the type of tonsillitis. This secretion may also cover parts of the mucous membrane around the orifices of the crypts so as to resemble a false membrane on the surface of the tonsil, and that from one crypt may coalesce with those from others so as more or less to cover the tonsil, but this does not tend to spread from the tonsil on to the surrounding anterior or posterior pillar or the uvula, and when touched and picked up it proves to be particles of cheesy material suspended in viscid mucus and not adherent to the underlying membrane, although this may bleed by being easily scratched by the instrument owing to the engorged state in which it is.

In the parenchymatous type the inflammation of the tonsils is a part of a general inflammation of the pharynx. They are uniformly enlarged and are as congested as the mucous membrane of the pharyngeal wall, but there is not the intense colour of the follicular type nor the tenacious sticky secretion. The tonsils are varyingly enlarged and may become more so than in the follicular type, but neither the enlargement nor the other signs of inflammation necessarily bear any relation to the severity of the attack, so that the most severe case of constitutional disease may be associated with the smaller amount of change in the throat; nor do the local signs necessarily bear any relation to the pain on swallowing, which may be great with few local symptoms, but which does bear a direct relation to the severity of

the attack. The secretion is not nearly so abundant as in the follicular type nor has it the same tenacity; sometimes even the throat may be unusually dry and such cases are likely to be exceptionally painful.

The duration of the attack varies from forty-eight hours to a fortnight, after which is a variable period of convalescence during which the disease is very liable to recur if the patient try to do too much. The follicular type is shorter than the parenchymatous, but the two overlap in the four, five, and six day cases. The local complications of this disease are peritonsillar cellulitis or quinzy and œdema of the mucous membrane. I do not propose to deal with complications to-day, but the œdema is more liable to involve the uvula in the follicular type ,and the margin of the epiglottis, the mucous membrane of the base of the tongue, and the aryepiglottis folds in the parenchymatous type. It may pass on to cause œdema of the glottis, but this is not common in the usual cases of tonsilitis. It is less unusual in the cases indicated above with intense pain and severe general symptoms without much abnormal to see in the pharynx either of the tonsils or of the pharyngeal wall. Such cases are probably those which were described as erysipelas of the pharynx and larynx, but they form an unbroken series clinically with the cases of parenchymatous tonsillitis. The hæmolytic streptococcus is the organism of erysipelas and is also most often found in the severe types of tonsillitis, while the non-hæmolytic streptococcus and other organisms are found in the milder forms. Lastly, these cases may be followed by erysipelas of the face or may themselves be secondary to such a condition. For these reasons I do not think we can definitely separate erysipelas of the pharynx from tonsillitis, but should look upon it as a more severe form of the parenchymatous variety.

The most important thing to decide in a case of tonsillitis is what to do with your patient. Is he or she to be stopped going to work? If so must he be confined to the house, and if so must he remain in bed? How long is he likely to be ill, will he have to have a trained nurse, and must he go away to the seaside when he is better? You will remember how Dr. B. H. Stewart laid stress to you on the importance in practice of prognosis, and how prognosis was not a thing that could be decided monosyllabically "good" or "bad," but involved an answer to every possible question that every relation or friend could put to you.

In acute tonsillitis a decision as to the "disposal" of the patient affords most excellent practice in developing your power of making such a prognosis, as well as being the most important point in the treatment of the patient. Your decision will depend upon half a hundred things, upon the severity of the attack, upon the age, sex, character, and physique of your patient, upon the nature, importance, and heaviness of his work, upon the site and length of hours of the same, upon the security of his job, and the relation of his wage earning capacity to his domestic affairs, upon his home conditions, and opportunities of being nursed, upon the time of year and the weather, and upon its effect on other people. It is quite impossible for me to exhaust the possibilities, but I will try to enunciate the principles by considering a few examples.

In the first place if any serious symptoms are present such as an œdema of the epiglottis or aryepiglottidæn fold so that a spread of this to the larynx may be feared, or if the general condition as exemplified by the rate and character of the pulse or the appearance of the patient is bad out of all proportion to the local signs, you will have no truck with any suggestions of continuing work, you will have the patient indoors and in bed. In the case of school children the importance of their work bears no relation to the importance of their health, and therefore you should always keep them away from school. There is an added reason for this in the infectivity of the lesion and the importance of not spreading it to others. Though you may think the sturdy child concerned quite fit to carry on, the child that sits next him may be a weakling who will catch his tonsillitis and develop a mastoiditis that endangers her life. You may have opposition from different directions in different classes of life. Among those not so well endowed with the world's goods you have the school teacher endeavouring to keep them at work because the school grant to some extent depends upon regularity of attendance. Amongst the wealthy who pay high fees for education, the opposition may come from parents who do not like to see their children kept from school for the milder cases of sore throat which seem to them a slight complaint. You will be

equally firm in either case; and as you keep the child away from school you had better keep him in bed for one or two days up to a week according to the severity of the case.

Take as another case a man in the city or high up in the ranks of the civil service. He has important work that must just be finished up, or the work of many others depends upon his presence there. With such a person you can often tide him over a day or so to the week-end or until the important work is done, or even enable him to carry on through the whole attack.

The difficulty of finding work is so great nowadays that with the clerk, the mechanic, or labourer, who has a family to keep, you should take any reasonable risk rather than put him in a position to lose his job; remember that anxiety reacts upon the body through the mind, and the mere chance of losing employment may do more to prevent recovery than remaining at work may do.

Other things being equal I think it well to have the patient in bed. Frequently twenty-four hours is enough, so that if he go to bed one day at 5 p.m. he can get out and sit up for an hour the next day and be up to lunch on the day after. I find that the longer they are kept in bed, the convalescent period is more than proportionately increased; but the stages of recovery each day must be gradual. If you start with a case on Tuesday with a view to his returning to work on Monday, you will not get him there if you keep him in bed till Saturday. You may do it if you have him up for an hour on Wednesday, four on Thursday, up to lunch on Friday, and out for an hour in the evening, and up after breakfast on Saturday and out of doors before lunch. A few days at the seaside or country are always well if it can be managed, but an important warning must be given that the patient must treat himself as an invalid, lie down for an hour after lunch and go early to bed—six o'clock for children and eight o'clock for adults,—and slowly graduate their exercise by doing very little for the first day or so. The same warning may be given to those who cannot get this change—early to bed immediately on return from work and have nine, ten, or even eleven hours in bed for the first few days after they begin again. Neglect of these precautions is very likely to result in a relapse with a more prolonged convalescence after it.

Now for drugs. The first is the initial dose of castor oil. Do not be put off by the patient saying the bowels were well opened this morning, more than that is needed—something that was described by an old practitioner as a "birch broom and a bucket of water." Castor oil is best because it is most certain in its action and can be taken at any hour of the twenty-four. It is best to see the patient take it yourself; there is then no nonsense about his being unable to swallow it. The next is the mouth-wash; this wants to be alkaline to dissolve the mucus, a bit sticky to hang about the mouth and nicely flavoured; it must not be so strong that it hurts the mucous membrane. For these reasons I use the following :—

℞	Lysol	1 part.
	Glycerine	50—s.
	Water...	49—s.
	Tr. Lavandulæ Co.	q.s.

To be used with an equal amount or more of hot water. No one can stand lysol stronger than 1 in 200, and many people not more than 1 in 300. I do not tell the patients to gargle; it is painful, and the irregular actions of the muscles under the inflamed area possibly do more harm than the lotion good under these circumstances. For this reason also for ordinary cases I do not paint the throat. I tell the patients to use the lotion as a mouth-wash, swishing it about inside of the mouth, to use it hot and to use it often. They have nothing else to do all day and might as well spend their time doing this. Remember, however, that in any acute illness a patient's will-power is lowered or gone. It is no use to put the lotion by the bed-side; let the nurse go to them and make them use it. So also do not always go badgering the patient with requests as to what he would like. He wants rest and is too tired to make up his mind. Give him the food and make him take it or as much as you can get him to take, and when he begins to get convalescent go and ask him then what he would like. During the acute stage it is so painful that he will only swallow fluids, and my stand-by is treacle posset, that is, hot milk into a tumbler of which a dessert-spoonful of golden syrup is stirred. Our mothers fed us on this when as children we had colds, and now we learn that they were physiologically correct. For the patient who has not a sweet tooth, hot milk soups take its place, tomato, potato, or simply a meat juice made up with milk. Sometimes, however, semi-solids hurt

less than fluids, and you can then use one of the patent foods sweetened, or thicken the soup with it. If the patient is in bed you need not worry about what he takes for twenty-four hours or forty-eight hours; but if you are treating him while he is up and about you must, and you must get him to take it little and oft. But in either case you should worry about the fluid; they cannot take too much and it is best taken hot except when it is very hot weather when they will take it best iced. I would advise you to get the nurse who is often a daughter or a wife quite inexperienced to write down the exact amount taken and then at the end of the twenty-four hours you know how many pints or cupfuls have been taken. It is surprising how vague are the answers which one gets to one's question how much the patient has taken. It is equally surprising how little the patient has had when you add up the list made in the last twenty-four hours after hearing that the patient has "taken well."

Aspirin is a most useful drug, but in my experience is nowadays most horribly misused. When the patient feels every bone in his body ache and knows not which side to turn a single ten-grain dose gives a heaven-sent relief and enables the patient at once to fall into sleep; but I do not believe in giving it regularly every six hours or in large doses to take down the temperature. My experience is that if you do this you will greatly delay convalescence because you will leave your patient weak and like a chewed string just as you are starting to get him about again, and I am confident you should not do so if you are treating the patient when he is up and about for you will almost certainly bowl him over and cause him to take to his bed. My advice is that you use the drug as you do morphia, by giving a dose when you think it necessary, and by allowing the nurse to give one other, but not two, before you see the patient again. Discourage your patients from dosing themselves with it; they are liable to abuse it and I know one young officer who had taken 120 grains in twenty-four hours thinking he would thereby keep himself with his battalion until an impending action began.

Potassium Chlorate is a most useful drug. The patients can suck tablets of it at any time or it can be given as a medicine and is often mixed with iron. The iron is not necessary at this stage but a course of it should be given during and after convalescence. I find Easton's syrup most useful in adults and Parrish's food in children.

There remains to be discussed the question of operation. I am informed that someone has been removing the tonsils during the acute inflammation, and a young otologist who told me this said he intended to try it, arguing that if you operate during the acute stage of appendicitis why not in acute tonsillitis. I am absolutely opposed to such a procedure; I think the dangers of operating in the presence of any acute inflammation of the pharynx are very serious, and that there is no analogy between appendicitis and tonsillitis. Whether you should remove the tonsils during the quiescent stage is another question which I do not propose to discuss to-day; but if you do decide to do it, take care that it really is the quiescent stage. In my opinion at least six weeks should elapse after the acute attack before the operation, and it is better to allow two months. Nor do I propose to discuss the treatment of complications of acute tonsillitis, because I wish to deal with the throat aspects of certain infectious diseases in their relation to tonsillitis.

In the sore throat of scarlet fever there is absolutely nothing that will distinguish it from various cases of acute tonsillitis. I have imagined that there is a tinge similar to that in the peeling tongue of a bluish colour which makes me suspicious of scarlet fever, but there are many scarlet fever cases without it, and it is seen sometimes without the disease. So also the follicular variety is relatively not so common in scarlet fever, but it does undoubtedly often occur. Hence in examining cases of tonsillitis we must always be on the look out for scarlet, especially in children, and if there is a history of the illness being ushered in with vomiting, the child should always be stripped and examined for a rash. There is a view put forward that scarlet fever is due to the streptococcus as though it were an allotropic form of simple acute tonsillitis. It would seem that a large number of house-officers and others about the hospital hold this view, which you are quite at liberty to do, if you are unable to develop the agnostic frame of mind. But when you go on to put forward the view that it is a question of a personal equation between the physician and the patient as to whether you call it scarlet fever or tonsillitis you are guilty, to my mind, of spreading very false doctrine and are tread-

ing on most dangerous ground. Such a frame of mind will lead to your not being careful to distinguish between the two and so to failing to notify an appreciable number of cases. Failing more knowledge, isolation is our method of preventing this disease and any case unnotified means an extension of it.. This is a serious matter, because at the lowest estimate the amount of permanent damage to the community that scarlet fever leaves in its train is very great. The damage resulting from otitis media has possibly been exaggerated by certain otologists, but although we have no exact knowledge of how much it is there is no doubt that it is very considerable. The suppurative changes are, perhaps, not the only otological results and the otological results are probably not the only permanent sequelæ. Hence, any frame of mind or line of action which inhibits prevention of the disease is a very great responsibility to you. Remember also that there is another view of the pathology of scarlet fever that is due to some infective agent unknown to us which very greatly lowers the resistance of the body to the streptococcus and other organisms in a way that the causative agents of measles and influenza probably also do. Lastly, do not forget that it is the law of the land that you should notify cases of scarlet fever, and any practice which causes you unduly to refrain from doing so is a grave dereliction of your duty.

In diphtheria the question is a different one, not so much of prevention of spread as of efficient treatment of the sufferer before you. The essential treatment of diphtheria is to put in anti-toxin, and to do so early; where anti-toxin is given on the first day of the disease the mortality is low, but it goes up by leaps and bounds with each successive day when the administration is deferred. Hence, we must not only be able to diagnose diphtheria, but to diagnose it early. A certain amount of delay in the diagnosis is due to the idea which some people have that the diagnosis of diphtheria is made by the bacteriological examination. This is not so; it is made by considering all possible evidence that you can have before you, of which the bacteriological is one point, and a less important point because it involves delay. Whenever a diagnosis can be made from the clinical evidence it should so be done, and the swab taken to clinch the matter or used as a help to diagnosis in cases of reasonable doubt. The characteristic lesion in the throat is the diphtheritic membrane. In this the serum clots as it is being exuded on to the surface and that on the surface becomes continuous with that in the superficial layers of the tissue beneath. Hence, there is a membrane falsely replacing the destroyed surface of the mucous membrane beneath. This, then, can be picked hold of, and as it is pulled away the ulcerated surface beneath bleeds. This membrane is white and opaque; it does not correspond in distribution to the surfaces of the crypts, but spreads over the surface of the tonsil; it also extends beyond this surface on to the mucous membrane beyond and is liable to involve the anterior pillars and the uvula. With this the patient is more ill than with the same amount of local reaction with most cases of tonsillitis, but the illness shows itself by pallor—especially of the lips—in a quiescent patient so that there is a waxy placid appearance of the face, in contra-distinction to the flushed anxious restless condition of tonsillitis or scarlet fever. Some say that the toxin of diphtheria is a non-irritating one to the nervous system compared with other bacteriological toxins; others say that the difference is merely due to the fact that the pain of the throat in diphtheria is much less than that of the other diseases. No matter which, the important part is that there comes to see you a quiet child with expressionless face who looks at you and avoids you not, but who is unusually pale, especially about the lips.

I would suggest that for your work here in the surgery you put these cases into four classes.

1. Those in whom you are confident that it is a case of diphtheria. Here you will send the case to the fever hospital at once, and if you take a swab it is for your own interest to see how often your clinical observation fits in with the bacteriologist. Remember that the bacillus is not always found at once, and so do not imagine you were wrong. Even at fever hospitals where they are expert at taking swabs, they sometimes fail three or even four times before they find it.

2. Those in whom you are fairly confident that it is a case of diphtheria, but in whom you think there is sufficiently reasonable doubt to warrant your not sending the patient to the hospital that day. Clearly this class must be small among children in whom the loss of time so involved is unimportant socially and vastly important medically. It should be limited

to wage-earning adults who wish to return to work as soon as possible, supposing your diagnosis to be wrong. In these let the patient wait till the report of the swab before you notify the case, but give him anti-toxin at once. In advocating this procedure I am often faced with that blessed word anaphylaxis, supposing he really do get diphtheria in a fortnight's time. My answer to that is that there are far more lives lost by deferring the treatment of diphtheria than ever there will be from anaphylaxis.

3. Those cases in whom you are pretty confident that the disease is not diphtheria, but remembering that it is human to err, would like the confirmatory support of the bacteriologist to your diagnosis. In such cases you neither notify the case nor give anti-toxin, but take a swab and see the patient next day. Remember in a doubtful case in a child whom you see in the morning that a direct smear is as valuable as a culture, some who work at fever hospitals say it is of more value. At any rate if you see the child during the time the laboratory is open you may get a report in ten minutes instead of having to wait till next morning. I mention this especially in the case of children because delay in them is of greater consequence than in the adult, and I draw it to your attention because it does not seem to be recognised as a possible means of observation by those working in the Front Surgery.

Amongst this class of case there will be a small number in whom there is a temptation to take a second swab after the first one is negative. If when you re-survey the clinical symptoms in the light of a negative swab, you are tempted to take a second, it means that somewhere at the back of your mind you really believe it is diphtheria. Hence you may take a second swab, but you must give anti-toxin. I think we may lay it down as a positive rule that anti-toxin should be given in every case in whom a second swab is taken. If it is diphtheria you have already lost twenty-four hours; if there is sufficient chance of its being diphtheritic to warrant a second bacteriological examination, you dare not risk another twenty-four hours without starting treatment.

Here, again, during the day a direct smear may come in useful, and we found the organism thus in a case at Out-patients a week or so ago in whom a negative report had been received that morning.

4. Those cases in whom you are quite sure it is tonsillitis and not diphtheria. Here I should advise you to avoid bacteriological examination unless the patient works where he is in danger of picking up the microbe, students, house-officers, or nurses working in the surgery, persons who have been near diphtheria cases and such like; of course, in these cases, if the swab is returned positive, you will administer anti-toxin.

I should like to give you some advice as to what you are to do when the bacteriologist reports the presence of a "diphtheroid" bacillus, or "an organism morphologically indistinguishable from the Klebs-Löffler bacillus." I should advise you to treat them all as positive swabs, unless the bacteriologist begins to find them in every throat that he is asked to examine, when the only thing to do is to tell him that "this practice must cease." It is reputed that the D.M.S. had to send such an order round in Egypt when the bacteriologists were finding such things in every case of septic sore that was examined.

Lastly, a few words about syphilis. Certain cases of secondary syphilitic throat are absolutely indistinguishable from a parenchymatous tonsillitis. I am suspicious that every syphilitic throat may pass through that stage. Remember that women, for anatomical reasons, are more likely to be ignorant that they have acquired syphilis than men, married women have no reason to believe they have acquired it, unmarried women are more prone to conceal it than men. Hence the majority of cases that we see in the throat department are in women. Do not for this reason go and diagnose every case of parenchymatous enlargement as syphilis, but if you have a case which does not yield to treatment as it should, and especially if there is an unusual enlargement of the tonsil, cast your light across the forehead of the patient and make an examination of the lungs an excuse to strip the patient to the waist when you can examine the skin and the epitrochlear glands.

On the Thursday before this lecture was delivered two small boys, æt. 7 and 6, were seen by me in the O.-P. Dept., both of whom were, in my opinion, suffering from a severe and rather unusual form of follicular tonsillitis.

White spots were projecting from the crypts and spreading over the surface of the tonsil. I put them mentally into Class III. (above) of cases in which the diagnosis of diphtheria has to be considered. I therefore took both slide and swab and sent them to the laboratory asking for a report as to whether the diphtheria bacillus was present or other organism. I told the parents each to bring her child up on Monday, feeling that if I were wrong they would be signed up from the surgery and be sent off next day. I was wrong, and in each case the diphtheria bacillus was found. They were signed up from the surgery, but *in each case the address was wrongly written on the signing up form* with the result that 48 hours or more were lost while the Public Health Authorities were tracing them. Dr. King Brown very rightly reported the matter to the Superintendent and thus I came to hear about them. From these cases I would point two lessons:—

1. Let us hear less about " streptococcal films " on the tonsil or pharynx. I hear men refer to them far too frequently. I do not know whence they are learning it, but they appear to think a very rare lesion to be the common one. A case in point rose last Thursday, a small child with a film all over the posterior wall of the pharynx, and a slight stridor was seen. A negative report for diphtheria had been received a few days earlier. One member of the firm suggested a " streptococcal film," but a direct smear on a slide proved it to be diphtheria. For practical purposes I should say that if one sees a streptococcal film one had better call it diphtheria till it is proved not to be so. Let it be remembered that in these severe cases of tonsillitis with a film extending beyond the surfaces of the crypts the bias of mind in the diagnostician must be in favour of diphtheria rather than against it.

2. The cases illustrate the importance of administrative medicine in the recovery of the individual patient. The organisation of and between the Hospital and the Public Health Authorities covers the possibility of cases such as these, and it was rendered futile by carelessness in the writing down of addresses. Either this mistake was made by me in filling in the bacteriological form, or by the man who signed up the cases on receiving the bacteriological report. It is this factor of human error which will let you down time and time again and against which you must be constantly on guard. The rules I would lay down are always to read the address over to the patient or parent after writing it down, and to use BLOCK letters for all surnames, names of roads and negatives.

This leads me to a similar point which was exemplified at O.-P. last Thursday. We sent away to the fever hospital a child to whom anti-toxin had already been given, but forgot to mention the fact on the slip sent with him. We remembered it in time for the dresser to spend half-an-hour telephoning first to the M.A.B. to know where he had been sent and then to the Hospital to inform them of the fact. To prevent such a mistake it is well to write at the top of the slip *in every case* whether or NOT the diagnosis has been confirmed bacteriologically, and whether or NOT anti-toxin has been given. One does not then forget to do so when the omission is important.

Papers by Guy's Men.

F. Bocquet Bull, L.D.S. Orthodontic Treatment Required at 23 years of age.—Dental Record, xli., 1921, p. 449.

P. Turner, M.S. Tumour of the External Ear.—Proc. Roy. Soc. Med., xiv., 1921, p. 97. Sec for Study of Dis. Childr.

H. W. Barber, M.D. Erythema Figuration Perstans.—Ibid., Sec. of Dermat., p. 89.

T. B. Layton, M.S. (1) Bilateral Abduction Paralysis in Exopthalmic Goitre, p. 55. (2) Frontal Sinusitis during Scarlet Fever, p. 56.—Ibid. Sec. of Laryngology.

R. O. Moon, M.D., B.Ch., F.R.C.P. Post Graduate Lecture on Prognosis in Cardiac Affections.—Med. Press and Circ., cxi., 1921, p. 186.

A. Ralph Thompson, Ch.M., F.R.C.S. Treatment of some Cases of Congenital Deformities of the Lower Urinary Tract, with a study of their Anatomy and Origin.—Proc. Roy. Soc. Med., Sec. of Urology, p. 57.

Change of Address.

Graydon Hume, médéciu résident, Hertford British Hospital, 72, Rue de Villiers, Levallois-Perret, near Paris. Tel. Wagram 52–58.

P. J. Briggs, M.A., M.R.C.S., 16, Nottingham Place, W.1. Tel. Mayfair 5438.

J. F. H. Stallman, M.B., B.S., 8, Kinfanns Road, Tulse Hill Park, S.W.2.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

The Biennial Dinner.

DEAR SIR,—Every old Guy's man should by now have received a notice of the forthcoming dinner, fixed for Wednesday, October 26th at the Connaught Rooms, but it is possible that some few notices might have gone astray, as it is not always easy to be quite sure of every address. If, therefore, any reader of this has not yet received a formal notice, I shall be glad if he will send me his name and address on a postcard. I should also be very grateful if anyone will let me know of any colonial Guy's men who he thinks will be temporarily in England at that time.

Notices have not been sent to present students, but all are invited to come to the dinner, and notices are posted in the Colonnade, Students' Club, Dental School and Library; forms of application may be obtained from the Librarian.

May I also remind those who have not yet notified me of their intention to be present that I hope to publish a preliminary list of acceptances in the next issue of the GAZETTE, and I should like that list to be as large as possible.

Yours sincerely
ARTHUR W. ORMOND.

7, Devonshire Place,
Upper Wimpole Street, W.1.
13th September, 1921.

Nursosis.

DEAR MR. EDITOR,—I am glad to learn from you that the prognosis of Nursosis is not so serious as I had believed, but I fail to see why your several confidants should consider themselves aggrieved by my remarks. Each and every one of them should be thankful that he remains, as I remain,

A. B. ROWSER.

DEAR SIR,—I read Mr. Rowser's article in your estimable publication with interest tempered by surprise; interest not in the matter, but in the motive of the article; surprise at its transparent ineptitude. Unscrupulous physicians have in the past attempted to steal fame by describing anew old diseases long known to the Medical Profession and by labelling them with new titles, preferably the name of the describer. Mr. A. B. Rowser has attempted to emulate their example in the most barefaced manner for he completely fails to conceal the fact that should his exploitation of an old complaint succeed in gulling your dis-criminating readers, he would by a little dexterous manipulation of his pseudonym proclaim himself to an acclamatory world as the original, the only Browser.

I am glad to see that your editorial columns reflect your opinion of this infamous imposture. Serious criticism of the article on its "merits" as a contribution to medical knowledge is, of course, neither possible or desirable. One of Mr. A. B. Rowser's statements will serve as an index of the value of the whole. He describes his so-called infecting organism as amorphous and slowly moving. To those best qualified to judge the absurdity of these statements is manifest. The first statement has been expressly denied by a distinguished Guy's surgeon and the extreme motility of the "organism" in question has long been recognised at Guy's.

However, the interest of this Mr. Rowser lies not in his position as a scientist, but as a pathological curiosity.

The article on Nursosis, and especially that part of it dealing with treatment, shows that the author is suffering from the distressing malady known as "Tête Gonflée" or "Cerebrum turgidum." The characteristic lesion of this disease is a puffy swelling of the cerebral cortex with consequent inflation of ideas. Mr. Rowser is obviously suffering from the more severe form which attacks Broca's area, and which calls for immediate treatment of the most drastic description owing to its tendency to become malignant. The treatment can safely be left in the hands of the nurse in charge of the case. If the treatment is sufficiently energetic the swelling subsides with extreme rapidity. The inflation of ideas disappears with equal abruptness, but treatment is usually followed by extreme depression which lasts for a variable period. Convalescence is rarely very prolonged, although relapses are not uncommon and the after-care is therefore exceedingly important. We trust that Mr. Rowser may be fortunate enough to receive early and adequate treatment and I am public spirited enough to offer to place Mr. Rowser in the right hands, should Mr. Rowser, his parents or guardians, so desire. Should his case not react favourably to treatment I would like to point out that although Guy's Hospital has perhaps unrivalled opportunities to study the disease in all its stages, there is as yet no pathological specimen in the Museum.

UBI LABOR, IBI HONOR.

The Nursing of Browser's Disease.

By J. SAWRED.

After reading the excellent article by Mr. A. B. Rowser on Nursosis, which appeared in a recent issue of Guy's GAZETTE, it occurred to me that a few remarks on the nursing of such cases would be of interest.

Every nurse knows how difficult it is to deal with a patient who makes no effort to overcome his infirmity. This is typical of Browser's disease. He does not wish to recover, and strongly resents all treatment. He persistently pursues the infecting organism, and though, as a rule, it shows very little inclination to attack him, he is never happy until he gets it.

The feeding of these cases is, now rations are happily a thing of the past, comparatively simple. Their capacity is really a striking feature. I have known piles of buttered toast disappear with alarming rapidity. All stimulants are discontinued. This, and a milk diet does much towards the recovery of the patient.

In the majority of cases the patient becomes lightheaded at the onset of the disease. The brain is seldom able to bear the extra strain put upon it. Lumbar puncture relieves the pressure temporarily. Cold packs are usually ordered for checking the delirium.

The Amœba Ancillaris is not at present well understood. It is a most valuable organism, and absolutely essential to the life of any hospital.

Space will not permit me to enter into the wonderful characteristics it possesses, and the important functions it performs. That these qualities are absorbed by the patient, there is not the slightest doubt. A few weeks after infection, his general condition is so markedly improved.

Before finishing, may I very humbly correct a paragraph in Mr. Rowser's article? Proposal is not always accepted. I have known several cases in which the patient has been repeatedly rejected. Of course these are never published, and they usually prove fatal.

TO AN INDISCREET BROWSER.

(From a doggerel bard.)

You write, Dear Mr. Rowser, with considerable skill;
You write as though you know your subject well.
You might, Dear Mr. Rowser (but I do not think you will)
Tell us how you ever had the nerve to tell.

Your peculiar inside knowledge of the species you describe
Lays you open to a very serious charge.
And the fact that you've developed into such a learned scribe
Makes it clear that your experience must be large.

Have *you* ever in the twilight done a "strictly private" round?
Have *you* ever felt the glamour in the dark?
Are *you* one of those lost creatures who thrice daily may be found
Lounging gracefully in Colonnade or Park?

Your encyclopædic learning makes the diagnosis plain
That to multiple affections you're a prey.
From the young Amœba Agni to the Cerulean strain;
They have one and all attacked you in your day.

Don't deny it, Mr. Rowser, for you'll never be believed.
But don't you think, when all is said and done,
That you've rather over-done it, with the wordy bricks you've heaved?
Your amazing indiscretion takes the bun!

P. R. D.

Peptic Ulcer:

Being a synopsis of the views at present held by American observers.

There has recently been in this country a great deal of discussion on causation, diagnosis, and treatment of peptic ulcer, and perhaps a brief account of the current opinions on this subject may be of interest to your readers.

Causation.—Rosenow of the Mayo Clinic has recently drawn attention to the importance of focal infection in the production of peptic ulcer.

In a large number of experiments, the cultures obtained from the infected teeth and tonsils of patients who were known to have an ulcer were injected into a series of animals and the results investigated.

The experimental production of ulcers in animals by feeding them with bacteria has been uniformly unsuccessful except in the case of starving animals, and it is certain that the normal mucous membrane of the intestine affords a definite protection against bacterial invasion by that route. In hæmatogenous infection however the results are different. In the case of a man with recent hæmorrhage from a gastric ulcer for which a gastro-enterostomy had been performed twelve years previously, five infected teeth were found and removed. After the removal of these teeth, which were infected at the time of operation, the patient's symptoms gradually disappeared under medical management. The streptococci cultivated were injected into four rabbits and 48 hours later on being anæsthetised, although they appeared normal, all the animals were found to have well-marked ulcers and areas of hæmorrhage.

In a number of experiments of this kind it was found that, in general, localisation in the stomach was the striking picture after injection of the streptococcus although lesions in the gall bladder were not infrequent; while the injection of bacteria obtained from cases of suspected cholecystitis, usually B.Coli, was followed as a rule by localisation in the gall bladder and pancreas, although localisation in the stomach and duodenum followed in some cases.

It is reasonable to assume from this evidence that focal infection plays an important part in the production of these lesions in man, and this would also explain their common association. It has been frequently demonstrated that chronic ulcer of the stomach or duodenum is frequently accompanied by chronic inflammatory changes in the head of the pancreas, while Dr. Hurst and others have pointed out that chronic appendicitis too commonly accompanies chronic peptic ulcer to be a coincidence.

Rosenow's work would suggest that these lesions are the result of the same etiological factor, rather than one being the cause of the other.

Reeves, of the Mayo Clinic, has investigated the arrangement of the arterial supply of the lesser curvature of the stomach and first part of the duodenum, with a view to finding an anatomical factor to explain the frequency of peptic ulcer in these situations. He showed that the plexus of vessels in the submucosa of the lesser curvature is formed by arteries which are longer, smaller, and without as free an anastomosis, as those in other parts of the stomach, while branches passing to the mucosa are distinguished by their tortuous course. It is reasonable to suppose that owing to this arrangement the resistance to the blood at this point is greater than in other parts, and as a consequence, the current is slower as it enters the arterioles of the mucosa.

The arrangement of the submucous plexus of the duodenum is similar, while in addition its blood supply is relatively poor in comparison with other parts of the duodenum.

If these vessels are more liable to occlusion by bacterial emboli, as it would appear, it is possible that this may be a factor in the production of peptic ulcer.

Diagnosis.—This is conveniently discussed under the the following headings:—

1. History.
2. Physical Examination.
3. Laboratory Findings.
4. X-ray Examination.

History.—A great deal of attention is given to the history as a rule. The relief obtained by taking food, fluid, or alkalies, and the relationship in the time of appearance of symptoms to the last meal are all of importance. The periodicity of the symptoms in duodenal ulcer is almost diagnostic. The condition of the patient, during the remission of the gastric and duodenal types, varies widely: with duodenal ulcer patients are often entirely free from subjective symptoms, whereas with gastric ulcer dyspeptic symptoms frequently persist during the periods of remission.

The differential diagnosis of the two conditions is no longer considered a matter of only academic importance, and it is now recognised that gastric ulcer is a much more serious condition than was formerly supposed, although less common, and in the Mayo Clinic duodenal ulcer has been found to be five times as common as gastric ulcer.

The differential diagnosis is made with greater certainty after the X-ray examination.

Physical examination.—This is usually of no great value.

Laboratory findings.—In the Mayo clinic the examination of the stomach contents is not considered of importance in establishing a diagnosis. Little attention is paid to the presence or absence of occult blood as it is felt that there are too many sources of error, both in its detection and in its interpretation, for it to be of much value. It is interesting to note that in a large series of cases of ulcer hæmatemesis only occurred in about a fifth of the number.

Regarding the analysis of the stomach contents, most authorities in this country are of the opinion that as an aid to diagnosis this examination has practically lost all its importance.

Although hyperchlorhydria is commonly present in duodenal ulcer this is by no means the case in gastric ulcer, as was shown by Smithies, who in an examination of 500 cases of gastric ulcer found that hyperchlorhydria was present in less than one-third of the number.

A more important consideration, however, is the evidence recently produced by Gorham which throws considerable doubt on the value of the methods at present in use to determine the acidity of the gastric contents.

The fractional method of gastric analysis is presumably based on the assumption that the gastric chyme after a test meal is a homogeneous mixture, and that a small portion aspirated at ten to fifteen minute intervals represents the acid concentration of the gastric contents as a whole at that period of digestion.

If this hypothesis is correct, then we should expect the acid concentration of different portions of the remaining gastric chyme to be similar at a given time after a test meal.

Gorham then proceeds to show that this, however, is not the case, and that the acidity in one part of the stomach may differ widely from that in another at the same moment. Sixty-five cases were examined after the following method:—The patient was given the usual test meal after removal of the fasting contents of the stomach, and forty-five minutes later the meal was aspirated in 10 c.c. portions in rapid succession until the stomach was empty. An equal mixture of all the samples was used to determine the average acidity. In the case of one patient with a perforating duodenal ulcer, confirmed by operation twelve hours later, the first sample showed only a trace of free acid, while in a later successive sample the free acid was 106, and the combined acid 118.

The average total acidity was 66, and the free acid was 55. This is an extreme case, and although the other examples given do not show so great a variation, the results on the whole are striking.

Pawlow in considering the movements of the stomach was of the opinion that "The contents of the greater stomach remain for hours unmixed, and that the gastric juice digests and dissolves the mass from the exterior inwards." Cannon was of the same opinion.

Gorham concludes that different portions of the gastric chyme may vary widely in their acid concentration, and that the sample obtained by the fractional method is not in the majority of cases representative of the gastric contents as a whole, such a sample only representing the acidity of that part of the stomach in contact with the head of the tube. It is obvious that this objection if substantiated, applies to all methods of obtaining the gastric contents for analysis, in which only a sample is taken for examination.

X-Ray Examination.—This is regarded by all authorities as extremely important in establishing a diagnosis of peptic ulcer, and in the Mayo clinic a correct diagnosis is reached by this means alone in over 95 per cent. of the cases sent for examination, confirmed by the operative findings.

The double test meal is used in all gastric examinations, the patient being given a motor meal six hours before the examination. The chest is first examined and the screen is then lowered over the abdomen to see if there is any residue in the stomach. The patient is then given a further meal of barium sulphate and, while he is drinking this, the stomach is carefully watched for any abnormality, and palpated to detect any tumour or irregularity. The barium is forced into the duodenum until it is completely distended and any spasm or irregularity of its outline noted.

Plates are made immediately after the screen examination and the diagnosis is made by comparing the plate with the screen findings. The patient does not return again, and the technique of the examination is simple and rapid; in a recent visit to the department I saw 45 patients examined and a diagnosis made in an hour and a half.

Carman classifies the X-Rays signs of gastric ulcer as follows:—

Direct signs. 1. The nitch.
2. The diverticulum. These signs are pathognomonic.

Indirect signs. 1. Organic hour glass stomach.
2. Spastic manifestations.
a. Spasmodic hour glass stomach.
b. Gastrospasm.

The nitch is the bud-like projection seen in the barium filled stomach, and the diverticulum is the pouch-like excavation resulting from the extension of a perforating into the adjacent tissues, usually the liver or pancreas. Both these signs are necessarily those of advanced ulcer. In the case of the small erosion, where both of these signs are absent, the indirect signs, as given above, are diagnostic.

For the differentiation of intrinsic and extrinsic deformity, atropine is given until the pupil dilates and the patient complains of dryness in the throat, and when hour glass contraction of the stomach is the only sign detected, this test should be very carefully carried out.

Carman is of the opinion that an hour glass contraction of the stomach that resists atropine given in this way, is a positive indication of a lesion of the stomach or duodenum, and regardless of whether or not the hour glass is present at operation, the surgeon will find the cause if he looks for it.

Retention of the six hour test meal, gastric hypotonus and alterations in peristalsis, are signs that may corroborate, but singly or in combination they have no diagnostic value since they are seen in other diseases, and at times in the normal stomach.

In Carman's experience an ulcer crater with a base of extreme size is to be strongly suspected of malignancy.

The X-Ray signs of duodenal ulcer he arranges as follows:—

Direct signs. 1. Deformity of the duodenal bulb.
2. Duodenal diverticulum.

Indirect signs. 1. Gastric hyperperistalsis.
2. Gastric retention of the six hour meal.

Deformity of the duodenal bulb stands first among the X-Ray signs of diagnostic value. This deformity may be the result of organic change, or may be the result of spasm, and this may be quite out of proportion to the organic change found at operation. Chronic appendicitis or chronic cholecystitis may cause deformity of the duodenal bulb, and this sign is therefore not absolutely diagnostic of ulcer, although it is usually an indication for advising exploration. The combination of hyperperistalsis and gastric retention, with abnormal gastric outline is diagnostic of duodenal ulcer with obstruction. According to Carman, hypermotility is not distinctive of duodenal ulcer, and is commonly seen in both gastric carcinoma and achylia.

Treatment.—The controversy as to the relative merits of medical and surgical treatment of peptic ulcers would seem, according to Carman, to be largely a matter of correct diagnosis, and in view of the fact that over 95 per cent. of all ulcers are demonstrable by the X-Rays, a diagnosis based on clinical evidence alone cannot be regarded as well established.

There is no doubt that in the past the stomach has been subjected to much unnecessary treatment, both by the physician and by the surgeon, when a diagnosis of gastric ulcer was more often made than confirmed. In the Mayo Clinic over 300 gastro enterostomies have been undone, and in none of these could any trace of previous ulceration be found.

Probably the best results are obtained by combining medical and surgical treatment, and many attribute recurrences after operation to inadequate medical supervision.

The procedures at present commonly employed in the surgical treatment of gastric ulcer are:—

1. Gastro-enterostomy.
2. Excision or destruction of the ulcer. (*a*) Alone. (*b*) With Gastro-enterostomy.
3. Sleeve resection of the stomach.
4. Partial gastrectomy.

Gastro-enterostomy. It is common knowledge that this operation gives much more satisfactory results in the treatment of simple pyloric stenosis than it does in the treatment of active ulcer uncomplicated by obstruction, and the fact that in the early days of the operation, it was reserved for cases of the former kind probably explains the enthusiasm with which it was received.

At present in the treatment of active ulcer, this operation by itself is only regarded as a palliative measure, and, in the opinion of most authortties in this country, should be discontinued in favour of some more radical procedure.

The exact part played by the anastomosis, except in cases of simple obstruction has always been a matter of much discussion. It is usual to attribute its beneficial results to a lowering of the gastric acidity, and C. H. Mayo expresses the view of most when he says that "the surgical treatment of ulcer is the best recognition of the medical treatment, in permanently overcoming delay or obstruction and lowering the acidity with the patient's own alkalies."

Gastric ulcer, however, is not always accompanied by an abnormal amount of gastric acidity; and further in many cases in which it is, gastro-enterostomy, fails to bring the acidity within normal limits. In tho Mayo Clinic, it is believed that the acidity is permanently reduced by 20 to 40 per cent. in 80 per cent. of the patients, but many believe that sooner or later it returns to its former value. Those who do not accept the "physiological" explanation of the operation, and there are many who think it unsound and unphysiological, believe that it is a drastic stroke in a vicious circle. Something produces an ulcer which in turn causes irritability, pain, and spasm; hyperacidity and hypersecretion follow; and associated with there factors are

retention, prolongation of the digestive phase of the gastric cycle, and the long contact of gastric juice, high in acid and pepsin, with the ulcerated area.

This sustains a low grade inflammation in the mucous membrane and consequent chronicity of the ulcer. Sustained chronicity only means repetition of the cycle and so a vicious circle is established.

Excision or destruction of the ulcer.—Most surgeons are of opinion that wherever possible an attempt should be made to remove or destroy the ulcer, if this does not entail too great an interference with the motility of the stomach. Anything short of this, except under exceptional circumstances is considered as only a palliative measure.

There are at least three considerations that would urge the ablation of the ulcer, viz. hemorrhage, perforation, and malignant degeneration.

It has been found here, that of the type of gastric ulcer that bleeds before operation, about one case in every twelve will bleed after operation if the ulcer is not removed. Perforation is estimated to occur in about seven per cent. of all gastric ulcers.

Concerning malignant degeneration there is a great deal of discussion; a few deny that it ever occurs, while the majority are of the opinion that it follows in about four per cent. of the cases. Many, however, think that its incidence is much higher.

Excision of an ulcer may be both difficult and formidable and in some cases may permanently interfere with the motility of the stomach; in such cases something more may be necessary, viz. sleeve resection or, partial gastrectomy.

Balfour recommends destruction of the ulcer with the cautery and it is usually stated that when an ulcer perforates it subsequently heals, and should the patient recover he generally remains free from recurrence. By this method the ulcer is destroyed with little sacrifice of sound gastric tissue, secondary contraction is avoided, hæmorrhage, early or late, is prevented and the possibility of maglignant degeneration is removed.

Excision or destruction alone is not usually practiced, although Deaver recommends it in the case of small ulcers on the lesser curvature, but combined with gastro-enterostomy it is regarded by the surgical staff here as being the most efficient and satisfactory method of treatment in the majority of cases.

There are a few points of interest in the technique of gastro-enterostomy by the Mayo method.

The edges of the incision in the mesocolon are sutured to the area selected on the posterior wall of the stomach, as soon as the lesser sac is opened, and before the anastomosis is begun. At this stage of the operation the lesser sac can be shut off with greater ease and certainty, and in view of the fact that a few cases of internal hernia have been reported in patients, in whom the lesser sac had been shut off in the usual way after the anastomosis hed been completed, this may be a point of some importance.

Only absorbable sutures are used for all layers in the anastomosis, in order to avoid as far as possible subsequent gastro-jejunal ulceration, and for the same reason the clamps are always applied at some distance from the cut edges of the mucous membrane to prevent unnecessary marginal trauma.

Sleeve resection of the stomach.—This procedure is recommended by W. J. Mayo in the treatment of certain cases of callous ulcer of the posterior wall of the stomach. These ulcers may present great difficulty on account of their size, chronicity and close adhesion to the liver or pancreas. The patients usually suffer continuous distress with occasional exacerbations of localised peritonitis, and are frequently very anæmic and sometimes cachectic. Excision with gastro-enterostomy although the operation of choice, is quite often impossible, and in some cases gastro-enterostomy by the anterior method may be justified. It has been found that 75 per cent. of these ulcers occupy the middle third of the stomach, and in those cases in which the ulcer is too large for excision, sleeve resection has been found to give good results. In those cases in which the ulcer is of this type and involves the pyloric end of the stomach partial gastrectomy is indicated. In those ulcers in which excision is possible W. J. Mayo recommends dealing with them through an incision in the lesser omentum in preference to the transgastric route, and following the completion of the gastro-enterostomy, he pulls the lower part of the great omentum upwards behind the stomach and sutures it to the site of repair, so avoiding subsequent adhesion of the stomach to the posterior abdominal wall.

Partial Gastrectomy.—Although this is not looked on as the method of choice here, there are many surgeons in this country who favour the more radical operation of removing the ulcer bearing area as originally advocated by Rodman some years ago.

Although it is supposed to prevent absolutely the recurrence of ulcer, this is not strictly accurate, and cases of recurrence have been seen after partial gastrectomy, while in the hands of most surgeons the operation is much more serious than the more simple method of excision and gastro-enterostomy. There seems to be no advantage in Moynihan's method, and here it is usual to employ the antero-colic modification of the Polya method, which is simple and satisfactory. In this method the suture line is less extensive than in the other methods, and chances of the anastomosis leaking are consequently not so great.

The surgical treatment of duodenal ulcer is more satisfactory than that of gastric ulcer, and 95 per cent. of the cases treated by gastro-enterostomy alone are permanently relieved.

In the case of gastric ulcer only about 80 per cent. of the patients are relieved after excision of the ulcer and gastro-enterostomy, while with gastro-enterostomy the percentage of cures is lower.

In the case of small ulcers on the anterior wall of the duodenum, Judd is of the opinion that simple excision is sufficient. It is yet too early to pronounce on the

results of this method. When the ulcer is small and in close proximity to the pylorus, W. J. Mayo advises excision of the ulcer and pyloroplasty after the method of Finney. This method is only applicable to ulcers on the anterior duodenal wall and to those cases where the duodenum can be mobilised. The majority of duodenal ulcers, however, are treated by gastro-enterostomy.

Gastro-jejunal Ulcer.—In the Mayo Clinic this complication is estimated to occur in about 3 per cent. of patients after gastro-enterostomy, although many think it is more frequent. It has been recorded after partial gastrectomy, but never after pyloroplasty. In a series of 83 cases in this clinic, about two-thirds of the patients on exploration showed no trace of the ulceration for which the operation had presumably been undertaken. In about a third of the cases the remains of an unabsorbable suture was found in the base of the ulcer. The majority of the ulcers were of the marginal or gastro-jejunal type, and the condition was found to be seven times more common in men than in women, a rather remarkable feature to which other observers have called attention. W. J. Mayo regards the use of the unabsorbable suture as the most important predisposing factor: Ochsner, on the other hand, thinks that the ulceration is due to a mechanical defect in the anastomosis, since in all his cases he found that the anastomosis did not drain the lowest part of the stomach, leaving a small pouch below the level of the stoma. Many consider that trauma is an important etiological factor, and the suture line necessarily devitalises an area of mucous membrane around the stoma, where the majority of secondary ulcers are found. Lack of efficient post-operative medical treatment may be a contributing cause, but whatever may be the essential factor, it would seem that the surgeon has failed to deal effectively with the underlying cause of the condition, for which the original operation was undertaken. Hyperacidity alone cannot be the cause of the condition, for although in the series of cases mentioned above it was nearly always present to some extent, in three cases there was an absolute achylia.

Diagnosis.—In addition to the points usually given in the diagnosis of this condition, post-operative hemorrhage is, here, looked on with suspicion more especially in those cases in which there is no history of this having occurred before operation. Gastric delay with retention is common, X-Ray examination has been found to give direct or contributary evidence in 65 per cent. of the cases.

Treatment.—Some operators content themselves with excision of the ulcer and reconstruction of the stoma, wherever that is possible. Since there are cases on record in which the ulcer has recurred as many as three times after excision and reconstruction of the stoma, it is generally thought that something more radical is required.

It is usual in this clinic to excise the ulcer, reconstruct the stomach and jejunum, suturing the latter transversely, and completing the operation with gastro-duodenostomy as practiced by Finney. This is regarded as the operation of choice by most surgeons in the treatment of gastro-jejunal ulcer, and would seem to raise the question as to whether this is not the best procedure in the initial instance, more especially if those observers are correct who estimate that this complication supervenes in 30 per cent. of all gastro-enterostomies.

It is usually stated that Finney's operation has the higher mortality, but in Finney's hands this is not the case, and its results are very satisfactory and compare favourably with those of gastro-enterostomy.—I am, Yours, etc. G. MASSIE.

The Mayo Clinic,
Rochester, Minn., U.S.A.
August 25th, 1921.

Dangerous Drugs Act.

AFTER many discussions and the spilling of much good, or indifferent ink, the Regulation as finally amended, came into force on September 1st.

With respect to dispensing, the opinion is expressed, that the Regulations will be much less irksome than was at one time feared.

Under the heading "Application," the Regulations state: "The drugs to which these Regulations apply are morphine, cocaine, ecgonine, and diamorphine, . . . and their respective salts, and medicinal opium, and any preparation, admixture, extract, or other substance containing not less than one-fifth per cent. of morphine, or one-tenth per cent. of cocaine, ecgonine, or diamorphine." "For the purposes of the foregoing provision, the per centage in the case of morphine shall be calculated as in respect of anhydrous morphine."

Somewhat like unto the lady's postscript, there is much information in the tails:—"Morphine, calculated as anhydrous."

The chemical formula ascribed to morphine, C_{17} H_{19} No_3, H_{20}, shows one molecule of water of crystallisation and equals 94–95 per cent. of anhydrous morphine.

Consider the salts, on the same basis:—

Morphine Acetate, C_{17} H_{19} No_3, C_2 H_4 O_2 $_3H_{20}$ = 70·5–72 p.c. of anhydrous morphine.

Morphine Hydrochloride, C_{17} H_{19} No_3 Hcl. $_3H_{20}$ = 75–76 p.c. anhydrous morphine.

Morphine Tartrate $(C_{17}$ H_{19} $No_3)_2$ C_4 H_6 O_6 $_3H_{20}$ = 73–74·5 p.c. anhydrous morphine.

The same principle may be applied to the salts of Cocaine and Diamorphine.

The following table of dilutions of salts of alkaloids and preparations containing dangerous drugs, shows a maximum strength of the admixture outside the scope of the Act:—

	Per oz.	Per drm.
Chlorodyne, B.P.C.	190 m.	22 m.
Cocaine Hydrochlor. ...	½ grn.	1/16 grn.
Diamorphine Hydrochlor. ...	½ grn.	1/16 grn.
Liq. Morphine Acet.... ...	120 m.	15 m.
" " Hyd.	106 m.	13 m.
Morphine Acetate	1⅕ grn.	⅛ grn.
" Alkaloid (cryst.) ...	1 grn.	⅛ grn.
" Hydrochloride ...	1⅛ grn.	⅛ grn.
" Sulphate	1⅛ grn.	⅛ grn.
" Tartrate	1⅛ grn.	⅛ grn.
Tinct. Opii.	95 m.	11 m.
Tinct. Chlorof. et Morphin. Co.	95 m.	11 m.

In addition to certain B.P. and B.P.C. preparations expressly exempted, the following are outside the Act:—Elixir Acetomorphine et Tapin, Glycerin Acetomorphine, but not Linctus Acetomorphine, which is included.

For the above table I am indebted to a card issued by the editor of *The Chemist and Druggist.* Intended primarily for the dispensing and retail chemist, this card contains much information likely to be of use to many other persons.

It will be noticed that the volume of vehicle used to dilute the medicament is, in most cases, the essential factor.

It is hoped that this information will be of some use to readers of the GAZETTE.

Nurses' Lawn Tennis.

We reprint below an account of the final of the "Nursing Times" Lawn Tennis Competition. This account was written for the "Nursing Times" by Mr. A. Van Homrigh, who was one of the umpires, and we republish it below with the courteous permission of the Editor of that journal.

Guy's Hospital Team:—Nurse Stubbs, Nurse Johnson.

London Hospital Team:—Sister Rutherfurd, Sister Kinder.

Result:—London won—6—4; 6—3; 6—2.

Sport and General.

GUY'S HOSPITAL TEAM:—(L.-R.) NURSE WHITE, NURSE JOHNSON, NURSE STUBBS, NURSE VIAN.

The first set was well contested. Neither side was rapid in settling down; there was a general shakiness about the play, in which all participated. London, however, quickly established a lead to 4—1. Then, in response to urgent calls from their supporters, Guy's rallied with such effect that they won the next three games, bringing the score to 4 all. This did not suit Sister Rutherfurd, who, serving steadily and assisted by a misunderstanding between the Guy's pair, won the next game, which, with Nurse Stubbs losing her service, gave London the set by 6—4.

In the second set London soon established a winning lead, making a score of 5—1 in their favour. Then Guy's won two games—the first by some indifferent serving by Sister Kinder and a flash of Nurse Stubbs's real ability in the serving line. London, however, won the ninth game and the set by 6—3.

In the third and concluding set Guy's managed to win only two games, so that London ran out fairly easy winners with the score as stated above.

On the whole the tennis shown was disappointing. No one could complain of its steadiness or the amount of patience shown by the players, but it would have been a refreshing change to have seen more dashing tactics employed. Of the two sides, Guy's were more competent to do this than their opponents, and we think their chances of success were materially decreased by their policy of trying to wear out the patience of their opponents by similar tactics. Nurse Stubbs is an aggressive and punishing player, but these qualities were held very much in reserve on this occasion, and her serving was not the best that she is capable of. Her partner, Nurse Johnson, worked indefatigably, but her drives lacked that little snap that was required to disconcert her opponents. There was also a lamentable frequency in the occasions on which both the Guy's players made for the ball; the London pair showed much better cohesion in this respect. Both Sister Rutherfurd and Sister Kinder can look back on the occasion with unmitigated satisfaction, for they rarely if ever made a mistake, and they worked hard and effectively together.

"B" MATCH.

Guy's Hospital Team:—Nurse Vian, Nurse White.

London Hospital Team:—Sister Point, Sister Scotland.

Result:—London won:—6—4; 6—0.

The first set provided the most interesting tennis seen during the afternoon, as the players went out for their shot, which was an improvement from the spectators' point of view. Guy's succeeded in establishing a lead of 4—3, but were unable to keep it. In the eighth game Nurse Vian served very weakly and her opponents won a love game. Both the next games were carried to deuce, but London succeeded in winning them and the set by 6—4.

In the second set Guy's fell right away, and except for the second game, which ran to deuce four times before London won it, they made no effective resistance. London won a love set. It is hard to explain this falling away, but the fact remains that, whatever the cause, Guy's resistance became weaker and weaker.

Sister Scotland and Sister Point are a tough proposition to be up against, and take advantage with the greatest promptness of any weakness displayed by their opponents. They played their usual sound game, and were not afraid to go out for a winning shot when the time seemed opportune. They combine excellently and their tactics and strategy are of a high order.

For Guy's, Nurse White did well and volleyed with effect, but with insufficient frequency. Any player with an eye and a wrist like hers should get much busier at the net. She stood too far away for one thing, and we certainly think she could have been more enterprising in intercepting drives than she was. Nurse Vian played better than we have seen her up to a certain point, but then, either from fatigue or from the hopelessness of her cause, she fell right away, which was an unfortunate happening for Guy's.

The standard of play in the final was in a way maintained, but we missed the aggressive spirit so admirably exhibited by Sister Becher last year. Some of the rallies on this occasion were of inordinate length, and made one sigh for a volleyer to bring them to an effective finish. As we have indicated, Nurse Stubbs could have filled this rôle, but except on a few occasions she seemed content to wait for a mistake on the part of her opponents, and in doing so was much too optimistic.

Football.

ASSOCIATION.

The Association Club, having all last season's first team players still "up," is looking forward to a most successful season. The Committee would be pleased if all who intend playing will, without delay, place their names on the lists provided, and would urge all to commence training now so that fit teams may be placed in the field throughout the season.

The 1st XI. has been entered for the Private Clubs Trophy (A.F.A.), while both teams have been entered for the A.F.A. Surrey County Cups (1st Round, November 5th). These being in addition to the London University and United Hospital Cups.

Strong fixture lists have been arranged for 1st and "A" teams. The 1st XI. will meet the following amongst others:—

Colchester Town, away; H.A.C., home and away; R.M.A., away; R.M.C., home and away; Old Carthusians, home; Old Grammarians, home and away; Old Malvernians, home; Old Citizens, home and away; Old Westminsters, home.

Fixtures are also being arranged for a "B" team for November, and will be added to if sufficient support is forthcoming.

Specialities.

THE REGULIN SYNDICATE, LIMITED, 14, PHILPOT LANE, LONDON, E.C. 3.

As a remedy for chronic constipation, the Regulin Syndicate, Limited, claim to have proved the efficacy of Agar-agar, which is prepared from certain marine algæ.

When combined with an aquæous extract of cascara, an excellent evacuant is formed to which the name "Regulin" has been given.

This preparation is so manufactured that it passes unchanged through the alimentary and intestinal tracts, and its action produces soft and easy evacuation.

Its therapeutic value has already been widely recognised.

The Regulin Syndicate do not advertise to the general public, but will be pleased to send samples and particulars to Medical Men on application.

THE LEVERLITE LAMP CO., LTD., 30, NEW BOND STREET, W.

The Leverlite Lamp is the last word in pocket electric lamps, and medical men especially, will find it useful in a hundred different ways.

It is altogether different to the usual variety, all of which are more or less unsatisfactory.

The Leverlite Lamp contains no battery or accumulator, yet it gives a brilliant light at all times, and never fails.

Its mechanism is most ingenious.

By simply pressing and releasing a lever, a small dynamo is set in motion, and thus the current is generated.

It is easily worked, cannot get out of order, costs nothing beyond the initial outlay, and with care, will last a lifetime.

It can be obtained direct from the Leverlite Company, or from any of their Agents for 30s.

Appointment.

W. F. R. Burgess, O.B.E., M.D. Lond., to be Master of the Apothecaries' Company.

Reviews.

Correction.

The price of Sir Berkeley Moynihan's book on "The Spleen and some of its Diseases," reviewed in our last issue, is 21s. net, and not 1s. net, as erroneously stated.

Birth.

COVELL.—On August 20th, at Constantinople, the wife of Capt. G. Covell, I.M.S., a son.

GUY'S HOSPITAL GAZETTE.

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To the Stranger within our Gates.

THIS is the first GAZETTE published in the new academic year, and will therefore be the first GAZETTE which the Freshman will read after his initiation as a Guy's man. So it is only right, that, in accordance with the time-honoured custom, we should devote most of our pages this week to welcoming him and to offering him advice and guidance at the commencement of this new phase of his life.

Thus it is, sir, that we, in all humility, address ourselves to you, knowing not whom we may address. For, in the fullness of time, you may well become a great scientist, or a great surgeon; it may be that you are destined to become Superintendent of the Hospital, perhaps President of the College of Physicians, or Editor of the GAZETTE. If you aspire to this last office, we trust that you may at least be spared the task, with which we are now faced—that of saying in a new and original way all the things which other editors have said to other generations of newcomers in other Students' Numbers.

Tradition demands that we shall first assure you of the general and whole-hearted welcome which the Hospital extends to you. But you will have little need for our assurance. You will have already felt this spirit of welcome. When you first entered the quadrangle its influence began. There was old Tom Guy, with a benevolent smile on his good old face, almost stepping down from his pedestal to greet you, the youngest of his sons, as you entered within the gates of his Hospital. During your years at the Hospital you will learn to value, and to love, that smile of old Guy's. You will learn to interpret its many moods. When you arrive cold and depressed, through a dismal drizzle on a dull winter's morning with the thought of a long day's work ahead, that smile will spell encouragement and you will run with a new vigour up the steps into the Colonnade. When at the end of the day, your work done, you rush helter-skelter off to catch a train, Guy will still be there, smiling amusedly down at your scurrying feet. When on Cup-tie days you clatter noisily away, motley clad, he will, with a happy laugh, wish you good sport and good luck; and when you return at night, bedraggled but victorious, he will share your smile of triumph. We hope, too, that in your time, Guy may once again be allowed that trace of devilment which always seemed to dwell in his smile when the firelight gleamed on it on New Year's Eve. Still all these are but passing moods, and Guy smiles on always. Can it not be that this is a smile of contentment which this good old man ever wears, because he realises the comfort which his bounty has enabled us to bring to some of the poor sufferers in this corner of our great city? That is the interpretation which we would have you prize and remember throughout your day's work; and if, when your time comes to take your leave of the Hospital, you can look back at old Tom Guy, and can feel in your heart, that he is smiling down approvingly on you for the part that you have taken in comforting his people, then you may go on your way rejoicing, for you will well have earned your proud title of "a Guy's man."

So, sir, though you may not find us very demonstrative, yet you may rest assured that you are most cordially welcome among us. And this brings us to our second traditional duty, which is to congratulate you, on your discrimination in choosing Medicine as your profession, and Guy's as your Hospital You have doubtless listened to all the talk there has been lately about the overcrowding of the profession. The schools are full to their utmost. The supply of doctors bids fair to exceed the demand. Already at the Hospital we have an indication of this increased supply of qualified men. House appointments which not many months ago could have been had almost for the asking, are becoming more and more competitive. But as Judge Parry has said of the Law: "By the nature of things a profession to be worth anything at all must be overcrowded, the struggle for existence must be strenuously fought, many must be called and few chosen, or a high standard of work will never be maintained." This remains equally true (though it loses its equivocal meaning) when applied to Medicine. If there had been no such incentive for us to do our best as individuals, as hospitals, and as nations, we would never have reached our present standard of learning in Medicine. So we are glad that the profession is overcrowded and we are glad that this fact is widely known. For under these circumstances we do not get a large number of men studying medicine who think more of the money they can earn than of the good they can do. That you have chosen to take up medicine at such a time shows that you must have some inclination for this work. As you get more and more advanced in your studies you will find this inclination growing; you will enter more and more into the life and the spirit of the Hospital; and you will wonder that there ever was a time when the smell of the hops seemed strange to you and the Borough folk uncouth. If you do not find that you love your work, if you are a square peg in a round hole, throw up the work before it is too late. We will not laugh. We will admire you for knowing your own mind, and for being plucky enough to acknowledge that you have made a mistake.

As to your work, it is not for us to tell you what to do, or how to do it. Throughout this number you will find much that will help you. There are articles here by the Dean, by the Senior Physician and the Senior Dental Surgeon. All of them, with skill and experience far surpassing ours, offer you advice on your future work. Further on (in small type) will be found accounts of the work of various Hospital departments, together with hints which may help you in planning your studies. The only advice we would give you is not to read too much. Especially when you come to your clinical studies, it is the practical side of your work which will count. The cases that you see and not the cases that you read about will be the ones which you will remember. Though you may acquire what seems to be only a confused jumble of facts yet in the end you will find that when this maze is straightened out, you will have learnt far more than you had realised. In the words of Trousseau:—

"Il faut voir, toujours voir, des malades. Ces matériaux confus que l'on amasse sans ordre et sans méthode, sont pourtant d'excellents matériaux; inutils aujourd'hui, vous les retrouverez plus tard enfouis dans les trésors de votre mémoire."

Interesting Cases in the Wards.

Under Dr. Fawcett, Dr. Ryle, and Dr. Marshall—		
Stephen	26.	Chronic nephritis, with epistaxis and cirrhosis of the liver.
	36.	Chronic pulmonary abscess.
	40.	Acute nephritis.
	41.	Arterio-sclerosis.
Under Dr. Hurst and Dr. Hunt—		
Addison	5.	? Pernicious anæmia.
	11.	? Pernicious anæmia.
	17.	Enlarged liver.
	18.	Tabes and aneurysm.
Mary	38.	? Addison's disease.

Change of Address.

T. Izod Bennett, M.D., M.R.C.P., Middlesex Hospital, W., and 2, Devonshire Place, W.

Frank Collar, 123, Gipsy Hill, S.E. 19.

Correction.

In the account of the Dangerous Drugs Act, published on page 378 of our last issue, the symbol H_2O, representing a molecule of water of crystallisation, was several times erroneously printed as H_{20}.

We are asked to explain this fact, which we fear made the article somewhat obscure in places.

Passim.

MR. ORMOND has sent us a long list of the names of the men who have already accepted his invitation to the Biennial Dinner. This list, though long, is not complete, and is not closed. Mr. Ormond still expects to get many more acceptances before the 26th. So far there are two classes of men who seem to have kept rather aloof. We refer first to men who are still at the Hospital. They say that the Biennial Dinner is a meeting of old Guy's men who were here years and years and years ago, and who will get together with other old fogies and talk and talk about the days when they used to go round the wards with Addison or Bright, all of which may be very interesting for a time, but—— And they shrug their shoulders and politely refuse to come. They too have got hold of the wrong meaning of the Biennial. It is not a reunion of old Guy's men, but of all Guy's men. They will see there not only men who qualified in 1880, but those too that qualified in 1920. They will see many old friends who perhaps a year back were their house officers or their companions in the football field, and who are now finding their feet in the outer world of practice. They will be able to compare notes and to laugh over initial discomfortures. But above all, they will be taking their place, perhaps for the first time, in that great friendly fellowship of Guy's men which is not delimited by the walls of the Hospital, but which extends far and wide the world over.

Then there is our second class of delinquents —the dental men. It seems that they have been under the impression that the Biennial was for "medicals" exclusively. When approached on the subject their attitude is —we have our own annual dinner at which we meet all our old pals, and we will only be in the way if we butt in on yours on the 26th. No idea could be more erroneous. Dental as well as medical men are most welcome to this reunion dinner. We have in the chair the best-loved of all your dental men, and it is almost your duty to attend in honour of your chief. You have three weeks left in which to make up your mind, but you should not need more than three minutes, and the sooner you send in your name the better will Mr. Ormond be pleased.

MEDICAL men have long realised the disadvantages at which a nurse works. She has to wait three or four years after leaving school before she can begin her training. On every hand she sees her classmates, who have chosen commerce, teaching, or one of the sciences, as their profession, advancing in their work while hers is at a standstill. When she does begin, she has long hours of drudgery before her ere she can gain her full knowledge of the art of nursing. "She makes her hands hard with labour, and her heart soft with pity." And, in the end, she leaves after her three (or more) years at hospital, only to find that her friend in commerce is by now firmly established in a remunerative position, while she has to accept the busier tasks of a public or private nurse, at a far lower wage. But it is to be hoped that these days are passing, and that soon the nursing profession will cease to compete so disadvantageously with other occupations for the services of the would-be nurse. On page 399 will be found an article which Miss Sheldon has written for us explaining the reforms which have been recently made in the administration of the nursing profession, and suggesting further schemes for making the profession more attractive, and for placing it upon a sounder economic basis. We feel sure that this article will prove most interesting to medical men, who, while sympathising with nurses in their efforts for reform, often do not have time to follow all that is being done to do away with the bad old times.

The time has now arrived for most of us to pay our annual subscription to the Clubs' Union, and voices are again being raised declaring the increased subscription to be an unfair extortion. Last year, when it was decided to raise this subscription from three to five guineas, we were promised that steps would be taken to see that all defaulters paid their subscriptions, or relinquished their privileges as members of the Club. We have no objection whatever to men abstaining from joining the Union provided only that they will not make an unfair use of the facilities paid for by the guineas of their fellow students. But there are at present men actually living in the College who are not members of the Club. Many others use the dining, reading, and smokerooms daily, without troubling to contribute their share of the expenses. We have even no guarantee that the men playing tennis, cricket, or football at Honor Oak Park are Clubs' Union members. This state of affairs is manifestly unfair, and must stop. Although the authorities promised last year to move in the matter, nothing was done, and a whole year went by without the least thing being done to put an end to this injustice. The Union rules provide that the names of defaulters should be posted, and that they shall be excluded from all the rights of membership. These rules are never enforced, and an unscrupulous man can go on using all the Club premises without anyone being the wiser. If only public opinion is strong enough, the Clubs' Union Council will be forced to act in the matter; its revenue will become absolutely or relatively increased; the subscription could be lowered, or the advantages increased.

[Since the above paragraph was written, we have received the revised proofs of the article on the Clubs' Union. We notice that, in it, the Honorary Secretary has reiterated his abortive threat of last year. We sincerely hope that this year he will have the courage to enforce the laws.]

On Monday last we had the pleasure of listening to a lecture given in the Physiological Theatre, by Dr. Fenton B. Turck, of Colombia University, on "Shock and the Rôle of Cell Necrosis in Medicine." Dr. Turck who has spent twenty-five years on research in this subject, told us of his discoveries, and of his hopes for the future. His audience was a very large one (when one remembers that the Hospital was still nominally in vacation) and was most enthusiastic. We are glad that Dr. Turck allowed himself to be persuaded to lecture at the Hospital, and hope that he will not be the last of the great thinkers of America, that we shall be priviledged to listen to, here at Guy's.

Arrangements have now been made for tickets for reserved seats in the covered stand at Honor Oak Park to be sold at the Hospital during the week before each First XV. match. They will be obtainable on Wednesdays and Fridays from 4 p.m. to 5.30 p.m. in Class Room II. in the Medical School. Their sale will begin on Wednesday next when tickets for the United Services Match will be obtainable.

A few Sundays ago the Borough was invaded by a curiously clad crowd of men on foot, in carts, and on horseback. There were cowboys, Indians, pierrots, comic policemen, and all manner of other characters (not to forget the "famous black cat.") They were members of an unpaid society, that makes a hobby of parading the streets of London and the suburbs on most Sundays in the year, collecting funds for the various Hospitals. Though their method is quaint, their object is a good one, and their results are not to be scoffed at. Their collection in the Borough resulted in £395 11s. 11d. being sent to the Hospital funds. Rumour has it that over two and a half tons of coppers found their way into the collectors nets and baskets on this one day. Thus do the poor help the poor to help the poor!

To Ward Clerks and Others.

By Dr. JOHN FAWCETT.

Our Editor has asked me to write a few words to the men entering the wards for the first time on our New Year's Day at Guy's, October 1st. I rather think Mr. Editor said, "a few words of advice," but advice gratis is seldom very welcome, and so perchance some reflections from 36 years at Guy's may be more welcome and temper to some extent the very ordinary counsel which I can offer you.

Those of you who have passed through your preliminary period of study here have already learned something of the meaning of "Guy's" to her sons; you have heard something of her great traditions, and you have begun to perform your part in the game in which you and your successors will in future play an increasingly greater share. You have made friendships with men who will go into the wards with you, and you will further cement, or dissolve, those friendships according to whether you find that the bonds which unite you are sufficiently strong to withstand the strain of learning the duties and facing together the responsibilities of your life's work now beginning for you in deadly earnest.

To those who enter the wards on October 1st as new-comers at Guy's we, one and all, hold out the hand of friendship, feeling sure that if you are made of the right stuff you will learn to love Guy's in the present and also for her past, as we have long since learnt to do. For it seems to me true to the experience of most of us that the friendships made in the wards and out-patient rooms, and later as house officers, are more binding and more permanent than those of our earlier life at school or elsewhere, for the reason that we come into touch more closely with the realities of life and with one another, than we have ever done before, and if we are to do our best for our patients we must pull together and do our share in the "give and take" of professional life in all its aspects, in which our probationary period in the wards is the first lap.

As students you will soon be brought sharply and generally unexpectedly, face to face with problems and difficulties which must be answered and dealt with promptly. This education in learning early to stand on your own feet or in helping others, are some of the most valuable assets of a medical training, and the chief factors in the evolution of the robust character and sturdy commonsense possessed by the average medical student.

Again, equally soon, will arise in you the desire to do something to help your fellow man, for to do our best for our patients is the main object of our work. Intimate contact with patients in the wards teaches you how to do this, if you only go the right way about it. The practical way is to look upon each of the patients allotted to you as more or less your own property, to show your personal interest in him and to try and obtain from him every detail of his illness, in fact to learn how to make a good report upon his condition. In professional life more mistakes are made by careless reporting than in any other way, the result of want of sympathy, of laziness, of insufficient patience to listen to the patient's story and of thinking that you, in your wisdom, can supply the necessary details. If you do not learn, while you are in the wards, how to report and describe the complaints of your patients you will never be a successful practitioner in the sense of rendering good service to them, and no amount of accessory X-ray or bacteriological examinations, and the like, will ever make you so. Indeed, in some cases, you will waste the patient's resources in carrying out investigations which, if you had taken the trouble to enquire properly into his history, would have been quite unnecessary. Therefore reflect, and remember that your period of service as a ward clerk is a most valuable and important one in your lives and if you neglect to make good use of it your loss is almost irreparable. Patients in hospital or elsewhere never forget the clerks or doctors who have gone thoroughly into their case, for they know well, none better, its value in arriving at a correct diagnosis.

One of the next practical points to impress upon you is to read all you can about the diseases of the patients under your care. No one can learn medicine from text-books or demonstrations. The art of finding out what is amiss with a patient is acquired at the bedside, by watching the doctor of experience examine a patient after hearing a good report of the illness, by the results of bacteriological or other special investigations considered to be necessary, and then by trying to piece

it all together, not only from the facts you have learnt about the individual in question, but from those acquired by reading and former experience.

Thus learn to use your eyes, your hands, and your ears, and to cultivate a sense of sympathy, and towards that end the wards and out-patient rooms at Guy's will afford you ample opportunities in every direction. You never can compensate for the omission to train those senses by all the book knowledge in the world. X-ray and other special examinations are invaluable in their proper place as accessories to knowledge, and indeed in no direction in the last thirty years or so have greater advances been made for the welfare of our patients than by the help we now obtain from these special investigations. The value of each and all of them you will learn in due course. Do not, however, overvalue them and never send a patient, for example, to be X-rayed, as I have seen more than once, before you have heard his story properly and examined him, for these are the ways of the "slacker," and by such means will you be led astray and so bring discredit upon yourself and deservedly so, but unhappily and undeservedly discredit likewise upon your profession.

Another reflection is to remind you not to forget your old teachers of physiology and anatomy, of chemistry and of biology, when you enter the wards. In no direction is there more hope of advance for medicine and surgery than in a nearer relationship between the medical man and his allies in the scientific departments. Everywhere, nowadays, we are attempting to facilitate the channels of communication and so utilize the resources of which formerly we failed to recognise the value.

If, for instance, you will try to recall your physiology, then some day or other you will meet with features in a case which your physician and surgeon cannot explain, and you will bethink yourself of your old teacher. Go and see him, talk it over with him, ask him what it implies, and perchance you may get on the track of a new line of thought and ultimately of something of value in the elaboration of knowledge for the welfare of your fellow men. To take only two examples, look what advantage accrued to the world in the war from the study of "vitamines," or formerly in the explanation of the cardiac mechanism by the researches of Gaskell at Cambridge.

Many opportunities of discussing chemical or physiological or anatomical problems will arise in the wards if you are on the look out for them, and nowhere will you have a better chance of elucidating them than is afforded you in a hospital with a large medical school attached to it.

All I have written in these reflections is very very old, but nevertheless true. It was on simple straight lines like these that the foundation stones of the work of our great men of the past were laid, men like Bright, Addison, Hodgkin, Astley Cooper, Hilton, and Wilks. It is to these men, to their colleagues and successors, to the great body of Guy's students scattered all over the world that we owe our proud position, and little as each one of us may be able to do yet we can all participate and lend a hand from the time of ward clerk onwards, and so help to preserve and enhance the fair fame of Thomas Guy's Hospital and School, and the goodly heritage to which we have succeeded.

The Medical Student's Life: Pre-Clinical Period.

By Professor T. B. JOHNSTON.

THE choice of a profession is one of the most important problems which a young man is faced with when the time comes for him to make up his mind what his life-work is to be. A very large number of factors come into play to affect the ultimate decision, and it is only a relatively small proportion of the men entering medicine who are irresistibly drawn to it for its own sake. It is not surprising that, in the cases of those men whose personal wishes have not determined the issue, there should be a certain degree of apathy discernible at first. But however apathetic a man may be at the outset, it is not long before he feels the fascination of the work growing upon him, and by the time he enters the wards and begins to assume responsibilities for the care of patients, keenness and enthusiasm have come to him. In medicine, even more so than in any other profession, a man must have keenness and enthusiasm if he is not to become a slave and drudge.

It is unfortunate that the first year of medical study is apparently lacking in the human inter-

est. Many medical students rather tend to regard their Chemistry, Physics and Biology as an unnecessary burden, handed down by tradition and having little real bearing on their future work. No greater mistake could be made. It is impossible to emphasise too strongly how essential it is for the student to have a thorough knowledge of the general principles of these subjects, if he is to derive the full benefit from his subsequent studies. Living processes, whether physiological or pathological, obey laws of chemistry and physics. Empyricism in medicine has had its day, but it is dying hard. The more fully chemical and physical principles are worked out for and applied to living processes, the sooner will empyricism disappear for ever.

No one wishes to check the desire of the student to reach the more obviously human interests of Anatomy and Physiology and, indeed, every encouragement and opportunity are given to him to complete his preliminary scientific studies within the period of his first academic year. "Well begun is half done" and the man who clears his first hurdle at the first attempt, never looks back during the rest of his course. It is, unfortunately, true that the "cramming" of a mass of facts or theories may get a man through an examination, but unless he has a firm grip of the general basic principles it would have been much better for himself, had he been rejected.

Admission to the dissecting room and the physiology laboratories marks the commencement of the second stage in the life of the medical student. Henceforward his work possesses an obviously human interest which very rarely fails to attract, but, despite their attractiveness, Anatomy and Physiology can only be mastered by whole-hearted effort and continuous industry, and mastered they must be if known facts of structure and function are to become so familiar as to be of real practical value, not only for the final period of student life, but throughout the subsequent career. Without a sound knowledge of Anatomy and Physiology it is impossible to deal with patients in a scientific manner. But the labour expended on these subjects produces other and equally important results. Powers of observation are trained, dexterity of hand and finger, in a greater or lesser degree, the power to criticise, to sift and weigh evidence—all these are acquired, not with the aid of the midnight oil, but subconsciously as the ordinary routine work is faithfully carried out. In this way true education results from a medical training and a wider mental outlook is obtained even before the clinical period is entered.

Eight terms are allotted to the pre-clinical subjects, and only a small minority of students spend more than nine terms in the school before they complete the second examination and are allowed to commence their clinical studies. In these eight or nine terms, as the case may be, the student's time is fully occupied, but there is ample opportunity both for mental and bodily recreation. Every man who is physically able to do so, should take up one winter and one summer game, for no medical student can do good work who is not thoroughly fit, and, from the very character of his work, no medical student can hope to keep fit unless he takes his exercise in a regular manner.

Abler and more experienced pens than mine tell of the clinical period which forms the third and last stage in the life of the medical student, and they describe the additional qualities which are acquired in the wards. Those for whom these lines are written have only recently entered Guy's, but although their clinical work seems to be still far distant, I can assure them that it will not be long before they begin to appreciate its atmosphere, and to feel that the title "a Guy's man" carries with it a certain responsibility to the past for the maintenance of a tradition, firmly established and admirably expressed in the words "Dare Quam Accipere," which tell of unselfish service in the past and in the present, and which must be our inspiration for the future.

To Dental Students.

By MONTAGU F. HOPSON, L.D.S.

"It is always a silly thing to give advice, and to give good advice is fatal."

The Editor asks me, at somewhat short notice, to write a brief article for this issue of the Gazette, addressed to students entering the Dental School. He does not suggest a title, but it is possible that he has in mind the words of R.L.S. "Youth is wholly experimental. The essence and charm of that unquiet and delightful epoch is ignorance of self, and ignorance of life." Does he wish me then to mar that charm by assuming the unthankful office of tendering advice, and for the third year in succession to

run the risk of incurring the disaster indicated in the witty epigram quoted above? I fear there is no doubt of it.

Now there must have been some reason for your choice of school. It may be that it is a tradition in your family to have a son at Guy's; you may already have friends here; or it may be that its reputation reached you in lands over seas. Whatever factor determined your choice it must obviously have been such as redounded to the credit of the school.

Rest assured then that we bid you a hearty welcome and extend to you the right hand of goodfellowship. That Guy's right hand will always be within your reach so long as you remain a good fellow, but I would impress upon you straight away that here we expect and demand a high standard of fellowship, not a suppression of individuality, but a generous surrender of all self-interest, in order that you may play your part in maintaining the traditions which have made our Hospital and School famous and honoured all over the world. In short, when you have been here some little time you will find that to be a true Guy's man entails obligations, for it is a high calling to which you will need to devote yourself for life.

In another column the Dean has something to say about work in the School. His very sound and practical advice applies with equal force to both medical and dental students. I would, however, emphasize the importance of the preliminary subjects. To those of you who have not yet done Chemistry and Physics I would say this, let those subjects be your first and chief concern. To let them drag along throughout your course in Dental Prosthetics is the greatest possible mistake. Get your Preliminary Science Examination over as soon as you can. Chemistry and Physics are the necessary preliminary to the study of Physiology and Anatomy, including special Dental Anatomy, and these together comprise the subjects upon which your life's work must be built. Unless you have a sound knowledge of what organs are like in health, of their gross and minute structure, and how their functions are carried on, you cannot possibly understand the changes produced in them by accident or disease. Hence you cannot pay too great attention to the normal. Further, many of the greatest advances in medical knowledge to-day are due to the researches conducted by workers in Bio-Chemistry, so that without a basal knowledge of the subjects you will neither be able to appreciate the significance nor the application of their discoveries.

Although you propose to practise a speciality your success will depend upon the possession of that wider knowledge which embraces the whole and not merely a part.

That you have to pursue a course of study differing from that followed by a medical student is due to the fact that dental tissues when injured or lost are not built up again by nature in the same manner as other body tissues. They have to be restored, in part or in whole, by foreign substitutes. Hence you need to possess a knowledge of materials and their properties, and be master of a method of technique not required by other practitioners of the art of healing.

But dental disease does not differ from disease in other parts of the body. It is only in its manifestations, and these are due solely to the peculiarities of the composition, structure and relations of the tissues involved. Teeth are not separate entities; they are living parts of a living whole. There is no such thing as Dental Pathology as distinct from General Pathology. Operative technique is of the utmost importance, but it is of no value, indeed, it may be exceedingly harmful, unless it is based upon a sound knowledge of general disease and the morbid processes thereby induced.

In your third and fourth years you will be engaged upon clinical work, which will add to your responsibilities, for you will become a servant of the hospital as well as a student in the school. Guy's is a charitable institution founded by Thomas Guy for the benefit and relief of the sick and deserving poor. It is a Public Institution and as such is subject to public criticism. It behoves you then, in your relation with the patients coming under your care to be ever mindful, first of their welfare, and secondly of the reputation this Hospital has gained during the two hundred years of its existence. The poor people you will come in contact with are deserving of the same care, courtesy, and sympathy that you will extend, I trust, to your private patients later on. Be thorough in your work, but let this thoroughness be tempered with consideration,

Finally, I would commend to your notice the following maxims :—

It is the function of a Teacher to help the Student to learn.

It is better to learn than to be taught.

Test all things and prove them for yourself.

Method and tenacity of purpose will carry one further than mere cleverness.

Work to know, not merely to pass examinations which are but necessary evils.

Observe, compare, reflect, record, and you may discover a new fact, for there are more things we wot not of than those we know.

"Wisdom is humble that he knows no more."

Obituary.

Dr. J. M. FORTESCUE BRICKDALE.

One wonders at times of the real man behind the surgeon and behind the physician, and one ever regrets the passing of some personalities. The recent death of Dr. J. M. Fortescue Brickdale, of Bristol, where he practised as a Physician, must have brought a pang of regret to many of his old friends and acquaintances who remembered him in the nineties. He came to Guy's from Christchurch, Oxford, a man of the world, a wit, a lover of music, and with a wide range and knowledge of literature. He seemed to hold an impersonal and detached view of life, and it was interesting to watch him advancing his arguments, and giving his reasons, and leaving them. He became Physician to Clifton College—happy unison.

The British Medical Journal in a very kindly appreciation says, "for some years before his death he had been churchwarden, and in religious thought belonged to the school of George Herbert and Nicholas Ferrar." Some readers will remember Ferrar's religious community portrayed in "John Inglesant," Brickdale was not so impersonal, after all.

He stood for something that was admirable in life—a son of Oxford—"the sweet city with her dreaming spires."

RICHARD GILLBARD.

THOMAS HERBERT MORSE, F.R.C.S.

Many old Guy's men will be sorry to hear of the death of Thomas Herbert Morse at Deal, on September 7th. He joined Guys in 1877. In 1884 he took the F.R.C.S. Shortly after he settled in Norwich. He was appointed Consulting Surgeon to the Watton and Cromer Hospital, Surgeon to the Norwich Dispensary, Assistant Surgeon to the Jenny Lind Infirmary. He took a keen and active interest in all branches of surgery but more especially in abdominal surgery and he soon rose to be one of the leading consulting surgeons in Norwich. He contributed many papers on abdominal surgery to the journals. He was president of the Norwich Medical and Chirurgical Society. Ten years ago while in the course of his duties he contracted Influenza, after which Myelitis set in and for ten years he has been quite paralysed in both legs.

These years have been ones of greatness of heart and temper and great Christian fortitude and cheerfulness. His life has also been saddened by the loss of three sons in the war. In spite of all his troubles he retained an intense keeness and interest in the profession and in professional matters and a love of Guy's Hospital and all its associations and memories. Throughout all these years of enforced inactivity and sorrow, there has been no complaint but always a bright and cheerful smile, a great keenness of scientific knowledge and brave Christian faith.

Notice.

The accounts in connection with the fund for presenting Mr. Hopson with his portrait have now been settled and audited, and may be seen by any subscriber on application to Mr. F. Lewin Payne, at 18, Portland Place, or to Mr. F. J. Pearce, at 57A, Wimpole Street.

Publications Received.

Hospital, Nursing Times, W. & G. Foyle's Catalogue of Second-hand Books on Sport and Physical Culture, Presidential Address delivered at Tenth Annual Conference (at Glasgow) of British Commercial Gas Association. The Dublin Journal of Medical Science.

Report on the Lectures delivered by Prof. Gyzi at the Criterion Hotel on the 15th and 16th September, 1921.

(By our Dental Correspondent.)

Those of our readers who were privileged to hear the lectures delivered by Dr. Gyzi, in the Criterion Hotel, on the 15th and 16th of September, will doubtless recall with pleasure the lucid manner in which this man of science expounded his theories in regard to certain aspects of Prosthetic Dentistry.

In his first lecture Dr. Gyzi assumed the role in which he is familiar to us all, speaking upon "The problem of replacing the efficiency of the human dentition and its solution."

Commencing with a brief summary of the events leading up to his production of the Gyzi-Williams Anataform teeth, Dr. Gyzi pointed out the ground that had been covered by the earlier investigators —Bonwill, Walker, and Bennett.

His own investigations upon this subject were completed, after the publication in the *Dental Cosmos*, of some of the conclusions he had formed, and a subsequent offer of co-operation from an American firm, and resulted in the manufacture of the Anataform teeth of to-day.

By a special arrangement of three series of facets upon each tooth of the Anataform Sets of teeth, a grinding surface is presented upon the three phases of occlusion—the working, incisive, and balancing bites.

In the finished tooth as obtained from the manufacturer it is somewhat difficult to recognise these three fundamental planes established by Dr. Gyzi. This is due firstly to the deep clearance spaces that have been cut to enable the triturated food to be easily expressed from the sulci of the teeth. Secondly, the broad facts which were the ideal for human teeth in situ in the mandible and maxilla put too much strain on the mucous membrane of the alveolar processes, and had to be made smaller and sharper, so that the food could easily be cut during mastication with the artificial teeth.

Dr. Gyzi has only one fault to find with the Anataform teeth, namely, that they are all of the same cusp-length, but unless the Adaptable Articulator is used in conjunction with teeth of a varying cusp length, nothing will be gained by the use of these perfected teeth with varying cusp lengths.

He has thus accepted a compromise, and has given out his well-known Gyzi Three-point Articulator along with the present Anataform Teeth, until the time when his teachings upon anatomical articulation will be universally accepted, and when the members of the Dental Profession will look around for further perfection of teeth and articulators. Then, when the demand has arisen, he will be in a position to have his perfected instruments and teeth placed at our disposal.

His second lecture was entitled "A Scientific Exposition of the Problems of Vulcanization." He demonstrated, in the first place, how contraction of the rubber took place during vulcanization, and secondly, how this shrinkage could be controlled.

The shrinkage he found to be due to—

1. Molecular changes in the rubber while undergoing vulcanization.

2. Contraction of the vulcanite after expansion at the temperature of vulcanization.

The first change was due to expulsion of the sulphuretted hydrogen formed when the vulcanizing temperature was allowed to rise above 300° F., and the subsequent diminution in volume. The obvious means of controlling this molecular change was to keep the temperature at 300° F. and not let it rise above that temperature.

The second change, due to contraction of the cooling vulcanite, could be controlled by varying the surface tension on either side of the plate. Dr. Gyzi accomplished this by placing tinfoil upon the lingual aspect of the plate, while the palatal surface was allowed to remain in contact with the rough plaster model. When contraction took place it did so away from the smooth surface of the tinfoil, thus preventing any distortion on the palatal aspect of the plate.

The excess channels commonly cut in the investment material constituted another source of danger, and control was here obtained by cutting the excess canals in a special manner advocated by Dr. Gyzi.

The differences between the co-efficients of expansion of the two kinds of rubber comonly used for vulcanizing purposes raised another difficulty which could only be overcome by using one selected rubber. Unfortunately no rubber, at present on the market, is sufficiently strong and yet of the requisite colour to admit of this procedure.

Dr. Gyzi's lectures were carefully thought out and well-delivered, and were indicative of his powers of careful observation and close scrutiny, powers that have won for him a position of high esteem among the members of the Dental profession.

Messrs. Fripp & Yeoman, of De Trey & Co., are to be thanked for having organised these two lectures by Dr. Gyzi, and for giving us an opportunity of hearing in person a man of whom we have read so much.

Correspondence.

To the Editor of Guy's Hospital Gazette.

THE BIENNIAL DINNER.

Wednesday, October 26th, 1921.

Dear Mr. Editor,—I am greatly indebted to you for so kindly inserting my previous letters in the Gazette.

I am now sending you a list of the names of Guy's men who have already signified their intention of coming to the Dinner.

In many instances men have asked to sit next some friend who has not yet sent in his form of application, so that the absence of these Guy's men from the dinner would be a source of disappointment to many. I hope, therefore, that those men who are coming will see to it that their friends are urged to come also.

The Biennial Dinner is a splendid opportunity to renew old friendships, and I hope that all who are still hesitating over their decision as to whether they will attend or not, will now help to make this a record success, by adding their names to the list and applying for tickets.

If any of your readers, medical or dental, have not yet received an invitation form, I hope that they will send me a postcard with their name and address and I will then communicate with them at once.

Yours sincerely,
ARTHUR W. ORMOND,
Hon. Sec.

7, Devonshire Place,
Upper Wimpole Street, W. 1.
26th September, 1921.

LIST OF GUY'S MEN WHO HAVE SIGNIFIED THEIR INTENTION TO ATTEND THE DINNER.

1869—1879

1869†Durham, F.
1870 Burroughes, J. E. B.
1877 Mansell, E. R.
1878*Beale, E. Clifford
Leigh, W. W.
1879 Howell, T. A. J.

1880—1889

1880*Ashwell, H. G.
Newnham, W. H. C.
1881 Shaw, L. E.
1882 Gibson, J. H.
1883*Meyer, Col. C. H. L.
Wright, H. H.
1884 Muspratt, C. D.
Pitt, G. Newton
Randall, R. M. H.
Tubby, A. H., C.B., C.M.G.
1885 Andrews, E. C.
Price, A. E.
1886 Greenwood, E. C.
Sandoe, J. W.
1887 Brownfield, H. M.
Holloway, S. F.
1888 Collington, F. A.
Holman, F. K.
Marriott, H. B.
Randall, P. N.
*Roberts, Astley C.
Robinson, W. E.
1889 Black, George
*Fripp, Sir Alfred, K.C.V.O., C.B.
Lansdown, R. G. P.
Rouw, R. W.

1890—1899

1890 Fawcett, John
Pilcher, E. M.
Spurrell, C.
Stevens, T. G.
*Swayne, F. G.
Thorne, J. M.
1891 Hopson, Montagu
Jewell, J. W. F.
Pollock, C. E.
1892 Birdwood, G. T.
Daldy, A. M.
*Fisher, W. H.
1893 Eyre, John
Hovenden, A. C.
Jewell, W. H.
Keay, Colin
Parfitt, J. B.
Young, F. C.
1894 Allport, A.
Brereton, F.
Cooper, H.
Hovenden, G. S.
Reynolds, B. G.
Robinson, W. E.
*Steward, F. J.
1895 Beadnell, C. M.
Collier, H. W.
Ensor, G. A.
Handley, W. F.
Partridge, A. H.
Stewart, H. M.
1896*Edwards, C. D.
Fagge, C. H.
Harris, W. O. W.
Howell, J.
Knowles, C. H.
Millbank-Smith, H. J.
Reed, J. C. G.
Robertson, James
1897*Bruce, H. W.
Cloud, F. H. L.
East, W. N.
Evans, C. R.
Fremantle, F.
Thornely, M. H.
Wakefield, C. F.
Way, M.
1898 Eason, H. L., C.B., C.M.G.
Henson, W. J.
McGavin, L.
Morgan, A. Kinsey, Junior.
Peatson, J. C. S.
*Rowlands, E. W. S.
Swan, R. H. J.
1899*Dowsett, E. B.
Miller, A.
Nicholls, F. J.
Parsons, J. E. H.
Payne, J. L.
Pearce, Frank J.
Penrose, A. W.
*Rowlett, A. E.

1900—1909

1900 *Bagshawe, Col. H. V.
Brydone, J.
Butler, J. A.
Corfe, E. W.
French, H.
Goble, E. W.
1901 Atkins, Sir John, K.C.M.G.
Bent, S. C. H.
Coplans, M.
Glover, J. A.
Gray, A. C. H.
Greenfield, D. G.
Hardenberg, E. J. F.
Roper, Richard
1902 Osburn, A. C.
Pinching, C. T.
1903 Mann, H. C.
1904 Cowper, C. M.
Hughes, E. C.
Leeming, A.
Woodward, H. H. M.
1905 *Bellingham-Smith, E.
Cameron, H. C.
Clarke, H. M.
Crofts, A. D.
McBride, J.
Payne, O. V.
1906 *Alcock, A.
Davies-Colley, R.
Goodhart, G.
Layton, T. B.
Malleson, H. C.
Ripman, C. H.
Stebbing, G. E.
Vandermin, H. T.
Zorab, A.
1907 Aubrey, H. P.
Barnett, E. P.
Carlill, H.
Jones, C. E. M.
Litchfield, P. C.
Munden, W. P. H.
Palmer, B. H.
Reynolds, R. J.
Saunders, S. McK.
Watson, J. N.
1908 Chapple, H.
Price, P. S.
*Reynolds, L. L. C.
1909 Attwater, H. L.
Bromley, L.
Greenwood, A. A.
Mills, C. H.

1910—1919

1910 Barber, H. W.
Cox, Neville
Elliott, E. L.
Gardiner, H.
Hunt, G. H.
Kidd, W. S.
Marshall, G.
*Mullally, G. T.
Penny, E. A.
Poulton, E. P.
Rayner, A. E.
Reader, N. L. M.
Thomson, G. Y.
1911 Billing, E.
Blake, G. A.
Cook, Frank
Daw, Hubert
Glendining, V.
Hind, J. R.
*McNair, A. J.
Mutch, N.
Sandison, A.
Slesinger, E. G.
Steinbach, H.
1912 Eccles, G. D.
Genge-Andrews, G. E.
Hoby, H. J.
Keith, T. S.
Mayer, J. W.
Munden, M. M.
*Smith, P.
Zamora, A. M.
1913 Evans, H. W.
*Hancock, A. C.
Hopson, M. F.
Leigh, H. V.
Ryle, J. A.
Tanner, W. E.
1914 Boswell, P. R.
Bull, Bocquet
Messenger, H. L.
Simmins, A. G.
Stallman, J. F. H.
1915 Coffin, S.
*Jones, J. P.
Lloyd, V. E.
Matson, R. C.
1917 Apergis, H. D.
Bulleid, A.
Conybeare, J. J.
Grice, J. W. H.
Staley, R. C. W.
Woodruff, K. M.
1918 *Gill-Carey, C.
Grace, W. H.
James, J.
*Millett, H.
1919 Griffin, J. H.

1920—1921

1920 Burn, J. H.
White, S. V.
1921 Noott, G.
Turner, Terence
Hopson, M. G. S.
Shaw, M. E.

* Vice Chairmen. † Date of Qualification.

Also Viscount Goschen, Sir Cooper Perry, Canon J. B. Haldane, Major Oswald Magniac, F. P. Whitbread, Esq., and the Editor of the Guy's Gazette.

The Welfare Centres and the Milk Question.

Dear Mr. Editor,—I have read with interest your comments on the action of the Ministry of Health in reducing expenditure upon the supply of free milk at Infant Welfare Centres. With the wisdom or want of wisdom of a policy of granting doles of food to the poor, I am not concerned. I do not doubt that symptomatic treatment of this sort for the disorders of the State is necessary at present. But what does concern us is the action of the Ministry in utilising the Centres for *Infant* Welfare as distributing Centres for this free distribution of milk. The literature from Germany proves that during the war, when cow's milk was unattainable and when the mother's diet was of the poorest, the infants have never done so well, because all were breast fed. The value of an Infant's Centre depends more than anything else upon its success in attaining the highest possible percentage of breast feeding among the mothers attending. If free doles of cows' milk are distributed, the mothers will come in order to get the milk, and for no other purpose, and the Centres will grow to be more and more identified in the minds of the mothers not with breast feeding and its sometimes difficult management, but with bottle feeding. Indeed, Mr. Editor, I would have you observe that the caricature which so excites your admiration represents the Minister of Health as holding in his left hand this same offending bottle. The destination of the milk, you see, is taken for granted.

But the matter is even more complicated. The Centres have been the distributors of the dole. The income of the Centres is calculated, I am told, on the basis of the number of mothers attending, so that the more milk given out, the more mothers will attend and the less will be the financial embarassments of the Centre.

That the Ministry is wise to exercise some control is clear. It would be wiser still if it would remove an incubus that is checking the efficiency of too many Centres, and arrange that doles of food should be supervised and distributed by some separate agency.—Yours sincerely,

H. CHARLES CAMERON.

23, Devonshire Place, W.1.
September 21st, 1921.

Cerebral Compression.

A Lecture given by Mr. Bromley in the Clinical Theatre on 31st August, 1921.

Gentlemen,—Compression of the brain may be the result of trauma or intracranial disease. These types of compression are clinically quite separate, the trumatic case follows an accident in which there is head injury and the symptoms are acute; when due to intracranial disease, the patient has probably sought treatment for a long time, suffering from defective vision, headaches or vomiting; or perhaps some weakness of the limbs, or fits.

Though the types differ, they have more or less the same pathology, in that both are due to increased intracranial tension.

Wher. traumatic, there is often associated with it, in the early stages, a state of concussion, for the reason that an injury sufficient to bring about increased intracranial tension will, at the time of the injury, give rise to concussion.

Concussion of the brain is a clinical state following injury to the head. It is due to a sudden check to the flow of blood through the capillaries of the brain, both in the cortex and medulla. The effect may be the result of a sudden displacement of the brain within the cranium; the cortex and medulla becoming subject to pressure. Acting on the anterior part of the cortex, this pressure produces unconsciousness, which occurs immediately on receipt of the injury, and may be of short or long duration. The effect on the medulla leads to a fall of blood pressure, the result of which is a diminution of cerebral circulation and consequent depression of the activity of all cerebral centres.

Clinically there are two stages:—

1. Insensibility.
2. Reaction.

The first stage comes on immediately on the receipt of injury—the patient is unconscious, but usually may be roused, though at times there is complete insensibility. There is loss of all power, the muscles being relaxed and flaccid. The pulse is rapid and feeble, respirations are shallow, and the temperature is low, often normal.

The second stage is marked by a gradual return to consciousness in which there is usually vomiting—some cases exhibit during this stage, a condition of cerebral irritability, with photophobia, when the patient is roused. Remote symptoms are, headache, confusion of thought, loss of memory and irritability.

Compression of the brain is a clinical state set up by increased intracranial tension, the circulation within the brain becoming impeded. When due to trauma there is complete unconsciousness from which the patient cannot be roused—the pupils are fixed, at first contracted, and later on dilated—the change of the contracted pupil of irritation to the dialation of paralysis occurs first on the same side as the lesion causing the compression. In severe cases, there is incontinence of fæces, and an overflow incontinence of urine. At times there are violent convulsions. The temperature is subnormal; the pulse full and slow, decreasing in rate, but finally it becomes weak and irregular; respiration is slow and laboured, becoming stertorous with the paralysis involving the soft palate; later on it becomes shallow. Spasms or paralyses of limbs occur in relation to the localisation of the lesion.

Compression when arising from an injury is sometimes of slow and gradual onset, and symptoms may not be present for some hours, or even a day or two, after the injury. When the onset is delayed, it suggests that reactionary hæmorrhage within the cranium has occurred. The injury may rupture a meningeal vessel, which, owing to the collapsed condition of the patient following the injury, may not bleed at once; with the improvement of the general condition, reactionary hæmorrhage may be set up, especially on exertion.

As an instance of this, I can remember a case in which a man had fallen and knocked his head, he walked to the surgery shortly afterwards, and on examination seemed quite normal; he was sent home. Two days later he was admitted with acute compression due to ruptured middle meningeal artery. He had spent his time since the accident wandering about aimlessly, endeavouring to get drinks in various public houses, but had been persistently refused on the ground that he was drunk.

When compression is due to intracranial disease, and not to the sudden effects of trauma, it is always of slow onset and pro-

gress, though finally a rapid increase of compression may occur.

The classical general symptoms and signs of compression due to intracranial disease are:—

Headache.

Vomiting, of cerebral type.

Optic neuritis, leading to atrophy.

Slow pulse.

Localising symptoms and signs, usually classified as: 1. Irritative, and 2. Paralytic, occur in relation to the site of the lesion.

The following case is one of traumatic compression:—

Case 1.—W.S., age 37. Fissure fracture of the vault of the skull with contrecoup cerebral laceration (without fracture).

This patient was admitted to hospital suffering from a scalp wound and concussion. No history of the injury could be obtained. He was quite insensible. Temperature 98·7°; pulse 71; respiration 22. There was a small scalp wound (abrasion) over the right parietal bone, about one inch in front of the lambdoid suture. No other injuries were detected.

On the following day, the patient was still unconscious, and extremely restless. The pulse (half-hourly record) fell to 40 per minute. Pupils were small and equal, they reacted normally to light. Cranial nerves were normal. Right abdominal reflex was diminished. ? Double extensor plantar reflex.

Operation was performed on the right side (December 20th, 1920). The scalp wound was excised, and around this a semi-circular flap of scalp was turned down. A fissure fracture was exposed passing from the area of the scalp wound backwards and ending in the lambdoid suture. A trephine hole was made at the anterior extremity of the fracture, and bone was removed along the track of the fracture. There was no depressed bone, and very little extradural extravasation. The dura was incised—there was no subdural hæmorrhage, and only slight bulging of the brain. The flap was replaced and sutured, the excised wound was closed. It was decided that, unless improvement occurred, the other side of the head should be explored. On the day following operation, the patient was still unconscious. The pulse, which had been 140 after operation, rapidly fell to 60. On the next day, patient was still unconscious. The right abdominal reflex was absent, and there was a double extensor plantar reflex. Operation was performed on the left side (December 22nd, 1920). A semi-circular flap of scalp was turned down to expose the posterior frontal and temporal regions. There was no fracture. A trephine hole was made, and the opening enlarged. There was no extradural hæmorrhage. On opening the dura, subdural clots covering laceration of the inferior frontal convolution were exposed. The brain bulged to some extent. The exposed area was irrigated with saline, the dural flaps were folded back, the scalp replaced, and the incision completely sutured.

Two days later, the patient was still unconscious, but less restless. After this, he gradually regained consciousness, and on the sixth day after the second operation, he could understand when spoken to loudly. It was then found that he had motor aphasia. The difficulty in speech lasted for another week, when it rapidly improved. Plantar reflexes became normal. The right abdominal reflex remained absent, and he had diminished power on the right side.

Now, eight months after the injury, the motor aphasia has completely disappeared, though he has occasionally slight slurring of speech. He gets about well, and has no paralyses or weakness. He has no headache, but sometimes a feeling of tightness in the head. The interesting features of the case are:—

The immediate concussion followed by severe compression (pulse rate 40 per minute) due to subdural hæmorrhage and cerebral laceration on the opposite side to the small scalp lesion and fissure fracture; the relief which followed a decompression operation; the period of unconsciousness, complete for five days, and incomplete up to nine days; the observance of motor aphasia as soon as consciousness returned, and its recovery.

The following are cases of compression due to cerebral tumour for which operations have been performed:—

Case 2.—P.M., Male, age 35. Cerebral tumour, with localising signs. Exposure of tumour and decompression operation.

This patient was admitted to hospital suffering from fits. The history was as follows:—

Whilst at Ypres, in 1914, patient was in a trench when a shell burst, 15 to 20 yards away, killing nine men. Patient was not wounded, but fell down unconscious—he regained consciousness in the trench. A fortnight later he had an attack whilst marching—he fell down, becoming unconscious, and was subsequently told that he had a fit. Since then he has had fits every few weeks.

A typical fit.—There is an aura which consists of a hot perspiration and greatly accelerated heart, followed by twitching and then spasms of muscles on the left side of the face. He then becomes unconscious. He remains unconscious for about 20 minutes, then gradually falls asleep, sometimes vomiting before sleep. During the unconsciousness he evacuates his bladder.

After a severe attack he suffers from a dull aching pain in both temporal regions which disappears in about six hours. During an attack he invariably bites the left side of his tongue or cheek, and he is described as being rather violent.

He had papillœdema of both eyes, the disc on the right side being swollen 1 mm., and on the left side nearly 2 mm.

Operation on the right side (January 20th, 1921). Anæsthetic, intratracheal ether, Dr. Shipway (see chart).

A large semi-circular scalp flap, with its base stretching from mid-zygoma to asterion, reaching to near the middle line above, was turned down; a trephine hole was made just below the temporal crest, and the hole enlarged to the size of about $3\frac{1}{2}$ in. in diameter.

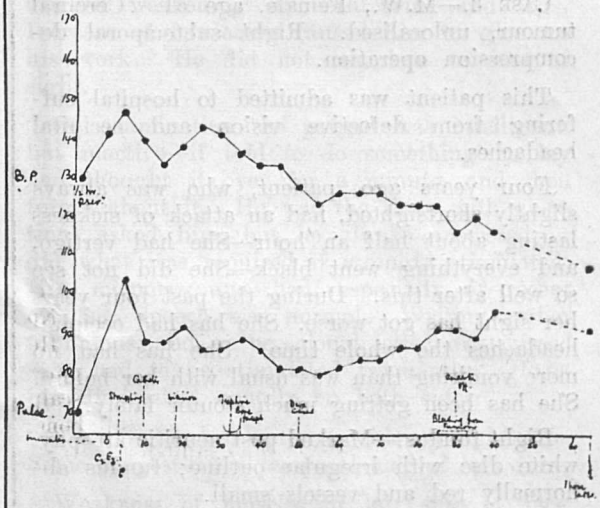
The dura showed the marking of an underlying tumour in the centre of the exposed area. The dura was opened, and split centrifugally—it was partially adherent in the centre, and was cut round (subsequently this adhesion was separated, and the portion of dura removed).

A tumour presented on the surface, surrounded by a dense plexus of dilated and tortuous vessels, which did not pulsate; the tumour itself, of which only a small central portion presented, had the appearance of a large thrombosed vein, dark red in colour.

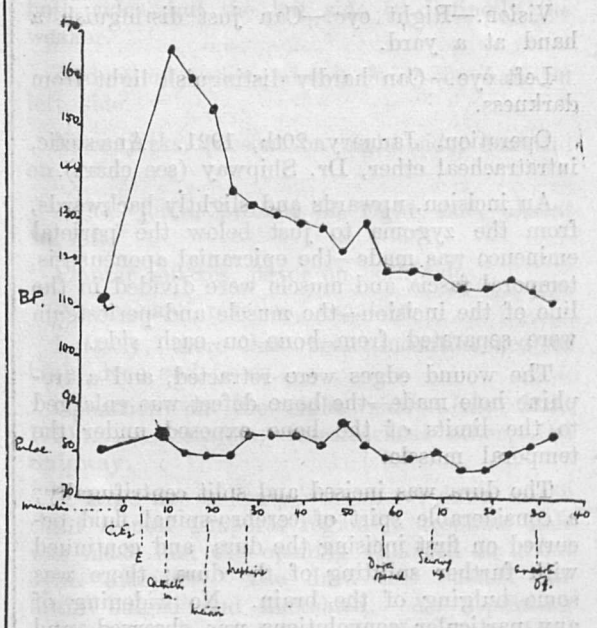
Although there appeared to be absence of pulsation in the vessels themselves, the whole tumour and area around pulsated. At the periphery of the exposed area, deep to the plexiform arrangement of vessels, apparently normal brain was seen.

The area involved consisted of, the posterior part of the frontal region; and behind this, the precentral (Rolandic) convolution, about halfway down the cortex.

Attempts to separate the tumour from its surroundings led to tearing of the small branches of the plexus, and bleeding—it was therefore decided to rely on decompression, and the scalp flap was accordingly replaced and sutured.



P.M. Male 35. Decompression for R. Cerebral Tumour Front Parietre region. Intratracheal Ether.
Dr. Shipway.



M.W. F. 51. R. Subtempual for unlocalised Cerebral Tumour. Intratracheal Ether.
Dr. Shipway.

Since the operation the fits have been rather less frequent and less severe, and for a while his sight improved. He has had seven fits in seven months, one he states was similar to those before operation, but the others have been of 3 or 4 minutes duration, in which he has not lost consciousness, nor had incontinuence of urine.

Case 3.—M.W., Female, age 51. Cerebral tumour, unlocalised. Right subtemporal decompression operation.

This patient was admitted to hospital suffering from defective vision and occipital headaches.

Four years ago, patient, who was always slightly shortsighted, had an attack of sickness lasting about half an hour—She had vertigo, and everything went black—She did not see so well after this. During the past four years her sight has got worse. She has had occipital headaches the whole time. She has had no more vomiting than was usual with her before. She has been getting much stouter lately.

Right fundus.—Marked post neuritic atrophy, white disc with irregular outline; fundus abnormally red and vessels small.

Left fundus.—The same condition, but more advanced.

Vision.—Right eye.—Can just distinguish a hand at a yard.

Left eye.—Can hardly distinguish light from darkness.

Operation, January 20th, 1921. Anæstetic, intratracheal ether, Dr. Shipway (see chart).

An incision, upwards and slightly backwards, from the zygoma to just below the parietal eminence was made—the epicranial aponeurosis, temporal fascia and muscle were divided in the line of the incision—the muscle and periosteum were separated from bone on each side.

The wound edges were retracted, and a trephine hole made—the bone defect was enlarged to the limits of the bone exposed under the temporal muscle.

The dura was incised and split centrifugally; a considerable spirt of cerebro-spinal fluid occurred on first incising the dura, and continued with further splitting of the dura; there was some bulging of the brain. No widening of any particular convolutions was observed, and there was no indication as to the site of the tumour.

The wound was then closed in layers with interrupted sutures.

1. Temporal muscle.
2. Temporal fascia.
3. Epicranial aponeurosis.
4. Skin.

A note on February 2nd, 1921, states:—Patient's vision has improved considerably; she can now distinguish persons.

On February 15th, 1921.—Right eye.—Can count fingers at 6 feet.

Left eye.—No perception of light.

Seven months after operation, this patient is in statu quo, the temporary improvement in her sight has not continued, although she is practically free from headaches.

Case 4.—F.W., Female, aged 31. Cerebral tumour. Bilateral decompression operations.

This patient was admitted to hospital for pains in the back of the head, giddiness and fits.

When 14 years old, she began to have fits, which came on suddenly with warning by peculiar taste in the mouth. She would bite her tongue and lose consciousness.

The aura would manifest itself 5—10 minutes before the loss of consciousness, and would still be present on recovery. It is described by her as a gumboil bursting into her mouth.

Before she began to have fits, she had temporary mental lapses—losing herself for no apparent reason. Since the fits began, they have recurred on an average of one each week.

She has suffered from severe headaches for several years—there has been occasional vomiting. She complained of failing eyesight for six weeks before admission, and a feeling of shakiness on her legs. The headaches have been steadily growing worse. Examination revealed a right-sided facial weakness, more marked on expression of emotion than on voluntary movement, and weakness of the right side of the tongue.

Pupils.—Not quite spherical, but equal and reacted to light (sluggishly) and to accommodation. Slight nystagmus when looking to the right.

Fundi.—Papil-œdema of both discs; advanced.

No impairment of sensation.

No marked weakness of limbs; right hand grip was, however, weaker than the left (patient is right-handed). No bulging over the head, but there was definite localised tenderness over anterior end of left temporal lobe.

Operation on the left side (February 17th, 1921) Anæsthetic, intratracheal ether, Dr. Shipway.

A large flap, including aponeurosis, muscle and periosteum, was turned down. A trephine hole was made, and the opening enlarged to expose the posterior frontal, parietal and temporal lobes. The dura was opened to the margin of the bone defect—there was considerable tension and bulging—the cortex was congested, and there was no pulsation. The temporal pole was elevated. No tumour was seen or felt on exploring the under surface of the temporal lobe towards the midline. The flap was folded back and the wound completely closed.

Following the operation there was extensive bulging of the brain, with loss of sensation and power in the right arm and leg. The bulging increased to an alarming size and it was therefore decided to do a further decompression on the opposite side of the head. This was performed on March 4th, 1921.

A bone defect to expose the right temporal region was made, the dura opened—there was not much bulging, and no abnormality of the cortex. The temporal lobe was elevated and no abnormality was seen. The scalp was replaced and sutured.

Subsequent history.—May 3rd, 1921.—Patient only has headache at periods. She has nystagmus. Her speech is normal. Both legs are normal, but she cannot yet move her right arm. The right side of her face is still weak.

May 23rd, 1921.—The patient's walking has improved. She has no headaches. Facial and tongue paralyses are still present. She tends to fall slightly to the right side when walking. The cerebral hernia is less marked.

Her general condition, 6 months after the second operation is very much improved. She has no fits, headaches or vomiting. She can read a newspaper. She walks quite well. She has partial paralysis of the right arm, which is steadily improving. The bulging on the left side is considerably less than formerly. She is rather slow at reading, but answers questions quickly and intelligently.

Case 5, T.L., Male, age 57.—Cliomatous cyst, right side. Decompression operation, and withdrawal of cystic fluid.

This patient was admitted for headache and weakness. Symptoms commenced in the summer of 1920 with intense headaches, chiefly in the right frontal region radiating to the right occipital region. This was followed by marked weakening of both arms and legs. Increase of headaches caused him to give up his work. He did not complain of loss of sight.

On examination the patient was intelligent, but inactive—if told to do something he lay and thought it over for a minute, and then forgot about it. He was the same with questions asked him, but he always answered or did what was required if strongly stimulated. His memory was bad, especially of recent events. Speech was normal. Writing rather tremulous, and an occasional letter was missed—he had to be stimulated frequently. Hearing diminished equally on both sides.

Fundi.—Marked optic neuritis on right side. Some congestion in temporal half of left disc.

Weakness of muscles of left side of face, including muscles of mastication, soft palate and tongue. Marked weakness of limbs on both sides, but the left side is distinctly the weaker.

Abdominal reflex, absent in lower half on left side.

Knee jerks, present on right side, doubtful on left.

Ankle jerks, present on right side, absent on left.

Plantar reflexes, flexor on both sides.

Wassermann reaction, negative.

Latterly, there has been incontinuence of both urine and fæces.

Operation on the right side (July 28th, 1921). Anæsthesia, intratracheal ether, Dr. Shipway.

A large flap of scalp was turned down in the right frontal temporal region—a trephine hole was made and the opening enlarged to about 3½in. diameter. The dura was opened—the brain bulged and fluctuated. An aspirating needle was inserted through the upper temporal convolution, and 50 c.c. of yellow fluid, the contents of a glomatous cyst, withdrawn.

The brain bulge collapsed. The scalp flap was replaced and completely sutured. The fluid withdrawn was clear and readily formed a dense albuminous coagulum. A marked improvement in the patient's general condition under the anæsthetic occurred on the removal of the fluid.

It is now one month since the operation, and the striking feature of his convalescence has been the relief of incontinence of urine and fæces—there has been no incontinence since the second day following the operation.

His general condition is much improved, and he gets about well, though slowly.

Guy's Hospital Clubs' Union.

The formation of the Clubs' Union, by the amalgamation of the various constituent institutions, took place in the summer of 1891. The objects of the amalgamation are to further the interests of the clubs and societies existing at the Hospital by their mutual support, and to simplify the collection of subscriptions. By the payment of an annual subscription (see Clubs' Union Year Book) to the Clubs' Union, any student of the Hospital can obtain the privilege of membership of the constituent institutions.

The Union comprises the following Constituent Institutions:—Association Football Club, Athletic Club, Boat Club, Cricket Club, Debating Society, Dental Society, Gazette, Golf Society, Hockey Club, Lawn Tennis Club, Pavy Gymnasium, Physical Society, Rifle Association, Rugby Football Club, Students' Club, and Swimming Club.

On joining the Union a Student is entitled to take part in the activities of any of the above Constituent Institutions. The ground of the Clubs' Union is under the control of the Council, is situated close to Honor Oak Park Station on the London, Brighton and South Coast Railway, and to Crofton Park Station on the South Eastern and Chatham Railway. It is nine acres in extent, and is the headquarters of the Guy's Football, Cricket, Athletic and Lawn Tennis Clubs. A Fives Court, under the management of the Students' Club, is situated behind the Nurses' Home near the Swimming Bath, and arrangements are made for classes in boxing and gymnastics in the Pavy Gymnasium. The Boat Club is affiliated to the London Rowing Club at Putney, and members are entitled to all the advantages of that Club. Meetings of the Debating, Dental, and Physical Societies are held from time to time in the College.

The membership subscription of the Union has recently been raised to five guineas. In spite of the large increase in the number of members, a rise in the subscription rate (perhaps only a temporary one) was necessitated by the rise in the cost of labour and material.

Extensive alterations have been carried out in the Students' Club to provide greater accommodation and comfort for the members, and are dealt with in a separate paragraph on the Students' Club.

At Honor Oak Park a new Stand has been erected to seat 800 people, so that now with the two existing small stands there is seating accommodation for 1,000 people. It is hoped that improvements to the Pavilion will be commenced shortly.

As any student can see, these alterations in themselves necessitate an increase in the membership subscription. The Utopian ideal of a new Students' Club may even yet be realised in the future, thus adding another burden to the finances of the Union.

Membership cards have been issued entitling the holders to the privileges of membership of each of the Constituent Institutions.

New members should consult the notice boards in the Colonnade for information as to the activities of the various Clubs.

An excellent programme of home matches has been arranged by the Rugby Football Club (*vide* Fixture Cards), and it should be noted that free admission to the ground during matches at Honor Oak Park is granted only to members of the Union on production of their membership cards.

Students' Club.

The premises of the Club include the Smoking and Reading Rooms and the Dining Hall, in the College.

All three rooms have recently been redecorated, and, in addition, alterations have been carried out in the Dining Hall and the Smoking Room. It is hoped in this way not only to increase the accommodation, but also to expedite the service during meal times.

In the Reading Room the periodical cases have been renovated and the paper stands have been brought up from the Smoking Room, where they used to be in a state of decay.

A good supply of papers and periodicals is now maintained, and it is hoped that all members of the Club will assist the Committee by themselves seeing that the periodicals, etc., are kept in good order. The taking of periodicals out of these cases or the removal of papers from the Reading Room throws a lot of extra work on to the Librarian, and members ought not to expect the Committee to keep up a constant supply of papers if these are continually

removed as soon as they are placed in the Reading Room.

The Library in the Reading Room has also been thoroughly re-arranged. A new catalogue has been made, and can be inspected at any time.

Notices are posted in the Reading Room stating the regulations of the Library, and students should avail themselves of this opportunity of a good supply of general literature which for once has no connection whatever with medicine.

Through the Library, books may also be obtained from Mudie's Library.

At a meeting of the Clubs' Union Council on September 26th the following officers were elected:—

President.—Dr. Lauriston Shaw.

Chairman.—R. P. Rowlands, M.S.

Committee.—F. J. Steward, M.S.; J. A. Ryle, M.D.; T. B. Johnston, M.B., B.Ch.; W. K. Fry, M.C., L.D.S.; P. O'Meara, A. H. Douthwaite, K. Hooper, R. Jarman.

Treasurer.—G. H. Hunt, M.D.

Hon. Secretary.—W. D. Doherty.

Asst. Secretary.—C. H. Toussaint.

Auditors.—Messrs. Toussaint and O'Meara.

The attention of all members is drawn to Rule 20 of the Clubs' Union:—

"Every member whose subscription is more than one month in arrear shall be suspended from the privileges of membership, and his name shall be posted in the Students' Club. After two months' default he shall cease to be a member of the Union, and shall not be re-admitted without the consent of the Council, who shall, if they think fit, impose a fine of five shillings upon his re-admission."

A list will shortly be posted in the Students' Club of members who have failed to comply with the rules, and the Secretaries of Constituent Institutions will be notified that the members named are not entitled to the privileges of the Union until their subscriptions have been paid.

W. D. DOHERTY,
Hon. Sec., Clubs' Union.

THE EDITOR will, at all times, be glad to consider articles or sketches, provided that they are accompanied by the writer's name and address, not necessarily for publication. The payment that the GAZETTE *can offer is merely nominal. Authors who desire reprints of their papers should make their own arrangements with the printers when they return their proofs. All contributions to be addressed to the Editor, "Guy's Hospital Gazette," Guy's Hospital, London, S.E.*

The Nurse.

"Je le pansay; Dieu le quarit."

A debatable and vital topic in numerous papers to-day is "The Nursing Profession," and many readers of the GAZETTE may wonder why.

All through their hospital life they were accustomed to the (apparently) endless progression of junior probationers, eventually evolving into the Head Nurse who in due time sorrowfully resigned her "strings" to another, and also to the immutable ward sister with twenty years of devoted and contented service.

The whole profession was, however, swept into the maelstrom of war unrest, though Guy's and other large hospitals have been less affected than many. Immense difficulties have been faced, and very much remains to be achieved, but we may confidently claim a reconstruction adapted to the post-war world greater than could possibly have been imagined eight or ten years ago.

Prior to that date the economic and social conditions of the nursing service were not questioned. The large Hospitals and Infirmaries were in all matters self-centred and self-sufficient, they had long waiting lists of candidates for whom the cachet of the hospital certificate was all that they required to obtain future employment.

Looking further back modern nurses, it must be remembered, are in direct succession to the women of noble family who in mediæval days entered convents to devote their learning and charity to the poor and sick.

In times nearer to our own the establishment of hospitals and asylums in and near the towns saw the appearance of the local day and night attendant (the Gamps) who combined the duties of cleaning and scrubbing with what little personal attention was considered necessary for the patient.

A tremendous change was wrought by the advent of Florence Nightingale and her teaching, when women of culture and character then entered the hospitals. It is impossible for us to realise the opposition they had to meet from the social prejudices of the time. The self-sacrifice entailed (which we cannot deny was their glory) formed a tradition which holds for both good and evil to-day. Also to their vocation, and its demands upon heart and mind, these women had to take over the hard physical drudgery of the Gamps, and to-day it is a vexed question where service of a domestic character connected with the comfort of the sick ends and nursing proper begins.

It is generally agreed that the nurse should be *taught* the right method of cleaning and keeping in order everything that appertains to her work, from the ward floor to the hypodermic needle, and certainly the probationer is now being relieved of much "ward work" and receiving the instruction referred to in the Preliminary Schools.

The introduction of ward orderlies has been advocated, but a difficulty not easy to solve in connection with such a scheme is that these women would quickly become a body of second-grade nurses.

To return to the pioneers of Miss Nightingale's day, thanks to their example and efforts, nursing became a recognised profession for all women. It can be seen that the absence of a nursing caste has made certain assessments of the needs of the profession not easy, and the pre-war age of entry from 23 to 33 brought economic difficulties in giving a short earning life. Indeed the economic side of nursing had received no attention, the probationer either paid a small premium or received "pocket money" salary and the pay of the certificated nurse was £25 or £30 per annum. The ward sisters appointments were eagerly coverted and generally held by women not entirely dependent upon their salaries, and prepared to give a life-times' service. Public Health posts were only in the making and by private nursing alone, with care and hard work, could any provision be made for the future. The end of the war brought an entirely unexpected cessation of applicants for nurse training and the gravity of the situation was quickly felt. The hours of duty and rate of pay were blamed so salaries were raised, and because of the urgency to secure service the scale for the untrained probationer was out of all proportion to the scale offered to the certificated nurse, especially in the fever and mental hospitals.

(Incidentally we look forward to the day when the nurse student will pay for her training and really adequate remuneration be the portion of the trained women.)

Then followed an impasse as the hours on duty, admittedly too long, could not be reduced without a larger staff and the larger staff could not be obtained wherewith to effect the reform!

These things will gradually right themselves for the profession has now entered upon a phase destained wherewith to affect the reform!

Our position to-day is:—

The Nurses' Registration Act was passed, 1919, and the Register is now open to all existing and intermediate nurses.

Nursing Councils for England and Wales, for Ireland and for Scotland are in being to administer the Act; these Councils have issued their several syllabus for the uniform (practical and theoretical) education of nurses and we owe to these Councils the deepest debt of gratitude for these most comprehensive pieces of educational work.

The State Examinations (compulsory after a period of grace) will be the one portal to the Register and and candidates must be presented by approved training schools.

The Hospital Authorities in consultation with the High Schools and Colleges recognise that a good educational standard will attract the educated girl and it has been suggested that school-leaving scholarships should be founded to enable her to take the preliminary part of the syllabus at a college or Polytechnic at 17 or 18 years of age, and to pass into hospital training at 19 to 21 (the present day age of entry). There are many schemes of training under discussion, affiliation of large and small hospitals, etc., so that the age of the probationer could be considered in arranging her starting point.

The State Register has its value, but also its limitations—the nurse must have living representatives.

For many years there have been various nurse societies, but without social and political power through lack of strength in numbers and unity of purpose. Much could be done by these societies in mutual conference, and also in conference with other women's organisations.

Guy's should take a special interest and pride in the College of Nursing (its membrship today is over 20,000) it was founded in 1916 as a scheme of co-operation amongst Nurse-Training Schools throughout the country, as the war had shown clearly the great need for some central authority and that it was no longer possible for the hospitals to exist in splendid isolation. Dame Sarah Swift and Miss L. V. Haughton were members of the first Council and Sir Cooper Perry, from the beginning has acted as Hon Secretary. Miss Hogg is upon the present Council and serves on special committees also.

To give a full account of the activities and aims of the College would require a separate article, but the full endowment of the College will crown its definite and far reaching educational policy, socially the gift of Lord and Lady Cowdray of a beautiful Club in Cavendish Square will greatly add to our pleasures and politically and economically an immense amount of work has been done. The report issued for 1921 mentions that a superannuation scheme is under consideration. In this respect Teachers and Civil Servants are in an enviable po-

sition, but it appears that the nurse of the near future will have the same important opportunity to make provision for her retiring age.

The writer would submit that in the profession material things have improved and are improving, and also the openings and scope for the trained women in scientific, health and welfare work and the new and attractive post of Sister Tutor among many others. Always the "nurse" will be wanted in hospitals, and by the sick in their own homes.

Something that cannot be bought and sold must attend upon the mysteries of life and death and for those who hold this gift there is a great need and unlimited opportunity for service.

F. A. S.

Reviews.

Therapeutic Immunization in Asylum and General Practice. W. Ford Robertson, M.D. (E. & S. Livingstone). Price 15s. net.

Dr. Robertson has contributed an interesting and agreeable volume to the literature of Bacteriology. Hitherto the books at our disposal on the subject of vaccine treatment, which is a less formidable description than this title, have been too brief and too technical for study by the average general practitioner. In this book, however, we have a very readable and comprehensive account of the preparation and administration of vaccines.

One cannot find much in this volume to criticise. The less sceptical of us may imagine that the millenium has arrived when Dr. Robertson asserts the benefit derived from this treatment in so large a number of diseases.

Pernicious anæmia, acute mania, and many other conditions not commonly treated from this point of view, are quoted as deriving great benefit from vaccines, and he certainly cites some interesting instances.

Time will show whether any real benefit is derived and it would be well worth while if in many of these diseases vaccines were given an extensive trial.

We cannot agree that the preparation of vaccines should be left in the hands of laboratory assistants however well trained, and he advocates their doing so after only twelve months experience.

The differentiation of the pneumococcia and the coli-typhoid group of organisms is, we consider too briefly described. His gravimetric method of estimating the strength of emulsions of bacteria is no doubt more accurate than the opacity method at present in use but we do not agree that the latter is as unreliable as he suggests especially in experienced hands, and his method is unlikely to be adopted where time is a consideration.

We miss the usual highly artistic pictures of the commoner micro-organisms but if their absence leads to the reader seeing them "in the flesh" so much the better.

It is a book that should find itself on the shelves of every practitioner who considers himself up-to-date, and is a valuable addition to Theropeutic literature.

Medical Science, issued monthly. (Oxford University Press.) Price 3s. net.

The difficulty of reviewing *Medical Science* is that it is itself a Review, and it is as impossible to criticise it as it would be to find fault with "Hansard" for the quality of the speeches which it faithfully records. The efficiency with which it fulfils its allotted task is shown by the catholicity and multiplicty of its contents. Its relatively low price should ensure its universal reading by the student (in the wide sense of the word). The reviews are complete in themselves, but the abstracts contain such a mass of information of so varied a character that it is difficult of assimilation, and much must necessarily be lost by the average reader who has no time to hunt up the indices in the half-yearly volumes. This might be obviated if the material of the various sections could be reviewed and classified at the end of the year.

The June number has an abstract of work on typhus which shows that the disease has, as usual, followed in the path of war. The value of a positive Weil-Felix reaction is again attested. Glatant claims to have reduced the mortality 15 per cent. by the intravenous injection of urotropin. There is a very interesting critical review of the Surgical Treatment of Intestinal Stasis in which Sir Arbuthnot Lane is adversely criticised for not publishing the end results of his colectomies, and it is pointed out that while, on the one hand, Lane declares that nothing short of total colectomy is satisfactory, and fails to substantiate his statements by furnishing results of his cures, Brewster, on the other hand, gives 19 cases, mostly of epileptics, of right colectomy with the most encouraging results.

The July number deals at length with influenza and respiratory diseases. Several observers, chiefly Americans, describe non-tuberculous chronic lung disease following influenza frequently localised at the apices and simulating the symptoms and physical signs of tuberculous disease, and others describe a "non-tuberculous" lung infection variously described as a "lobular form of bronchopneumonia of long duration," "localised bronchitis," and other such names in which B. influenza is found as well as the

other predominating organism of the mouth which also simulates tuberculous disease. The simulation is so close that the sceptical will view the evidence in these cases, with their clumsy titles, with grave suspicion, especially as the organisms discovered are the usual secondary invaders in pulmonary tuberculosis.

The August number contains abstracts of dysentery, congenital syphilis, and anoxæmia in the production of symptoms in disease and injury of the nervous system.

A Manual of Midwifery for Students and Practitioners. By Henry Jellett, B.A., M.D. (Dub. Univ.), F.R.C.P.I., L.M., and David G. Madill, B.A., M.B., B.Ch., B.A.O. (Dub. Univ.), L.M. 3rd Edition. (Messrs. Ballière, Tindall & Cox, London.) 1921. Price 42s. net.

The reputation of the Rotunda Hospital in all matters pertaining to the theory and practice of midwifery is so assured that one necessarily approaches a book bearing the mark both of an ex-Master and an ex-Assistant Master with no little respect. To the average student midwifery is the subject, above all others, of which his knowledge is based on practical experience. Both on the District and in the Obstetric wards he has unrivalled opportunities of becoming acquainted with the practical side of a branch of his art which is, admittedly of a more definitely limited scope than the others in which he has to make himself proficient. This being so it is not surprising that the teaching of the individual school to which each student is attached impresses itself very firmly upon his mind. In midwifery it is usually true, as it is only partly true of the sister arts of medicine and surgery, that the text-book only serves to refresh the mind on details which have become familiar from first-hand acquaintance.

Perhaps this is why students at any particular medical school tend to read the same text-book of midwifery while patronising a wider variety of text-books on the sister sciences. At any rate we doubt whether many readers of the Gazette are well acquainted with the book under consideration, and, if this be the case, we can only say that the loss is theirs, for it is an admirable work. Obstetrics are fairly cut and dried, but not so much so that the small differences in the manipulations and therapeutic measures do not give food for reflection. We cannot, indeed, find much that differs from our habitual practices here, but the very fulness of the work ensures due attention being paid to all alternatives. It is a large work, as such text-books go, but it is quite admirably arranged and the illustrations are numerous and—more important—they are instructive. One so often finds medical works with illustrations which seem to have been collected and inserted as a concession to a convention and with little real educational value. A particularly valuable point in this connection is the very complete set of illustrations of obstetrical instruments which should be of real service to the examination candidate.

The publishers' "University Series" is well known to all students and medical men and is sufficient guarrantee that their part in the production has been competently carried out. For a full and up-to-date treatise on this subject the book amply fulfils the promise inspired by the qualifications and experience of its authors. We can very confidently recommend it to all who wish to ensure their proficiency in this important branch of the practice of medicine.

The Pavy Gymnasium.

The Pavy Gymnasium, which is situated within the College, was founded by the late Dr. Pavy, F.R.S., and, during his lifetime, kept up by an allowance made by him. At his death the upkeep and maintenance of the gymnasium was provided for by a bequest in his will.

All Members of the Clubs' Union are Members of the Pavy Gymnasium. No student will be admitted to the privileges of membership until he has become a Member of the Union.

Instruction is given in Boxing, Fencing, and Gymnastics, and a hearty welcome will be given to any new Students who wish to avail themselves of these facilities.

Boxing Classes will be held on Tuesdays from 5 p.m. to 7 p.m., commencing on Tuesday, October 4th, when all those interested are requested to attend. This year we shall again meet Oxford University against whom we did so well in the past season. The competition has been fixed for November 5th, and will take place at Oxford. Boxing trials will be held in the third week in October, in order to choose our representatives. It is hoped that some more fixtures will be arranged.

Gymnastic Classes will be held on Friday evenings from 4.30 to 6.30 p.m., commencing on Friday, the 7th October. Instruction is given chiefly in apparatus work, horizontal and parallel bars, rings, and horse. The class is divided into an elementary and an advanced squad, and instruction is graded to suit the ability of the individual. Several fixtures are being arranged, and it is hoped to give a display at the end of the Christmas session.

Fencing Classes, under the excellent instruction of Professor Felix Gravé, will take place on Thursday evenings from 4 p.m. to 6 p.m. Prof. Gravé also instructs occasionally at his School of Arms, and invites keen men to meet him there for special instruction.

The Gymnasium is available for the use of members between the hours of 8 a.m. and 8 p.m. There is a shower bath immediately adjoining the Gymnasium, with hot and cold water; this is specially for the use of people using the Gymnasium. There are also a number of lockers available for members. Particulars of these may be obtained from the Honorary Secretary, N. L. Lloyd.

Boat Club Dance.

The Boat Club Dance will be held at the Wharncliffe Rooms, Great Central Hotel, Marylebone, on Thursday, November 3rd. Dancing 9—2. Swastika Syncopated Orchestra.

Lady Fripp has very kindly offered her services as hostess, and the following have offered their generous support:—

Mr. Davies-Colley (*President*) and Mrs. Davies-Colley.
Sir Alfred and Lady Fripp.
Mr. and Mrs. H. L. Eason.
Dr. and Mrs. J. Fawcett.
Mr. and Mrs. R. P. Rowlands.
Dr. and Mrs. H. French.
Prof. T. B. Johnston.

Tickets 25s. double (including Buffet Supper) may be obtained from the Wills Librarian, or Messrs. M. E. Shaw, R. S. Chambers, A. Tom, R. F. H. Duncan, R. Jarman, C. H. C. Trussaint, or from

G. C. Hughes,
Hon. Sec. Dance Sub-Com.

It is hoped that many past and present Guy's men will attend and help, while enjoying themselves, to keep the youngest of our Clubs going.

Football.

RUGBY.

GUY'S v. CATFORD BRIDGE.

Contrary to the general rule, Guy's opened their Rugby season in mid-September, the first match being against our neighbours at Catford. The Bellingham field was terribly hard on Saturday, September 17th, and the game was played up and down the hill, and not lengthwise in front of the dressing rooms, as is usual.

W. D. Doherty, P. K. Albertijn, C. L. Steyn, and C. Marais were the chief absentees. F. W. Reitz is out of his year, so he does not count. Reitz will be a big loss. He could play anywhere except, I think, at half-back, and in any position in which emergency placed him, he played well.

Catford with the wind and a drizzle in their faces did very well during the first half. Like ourselves, training had not yet left its mark on them, and practice had been scarcely indulged in. R. Hirschberg was the first to score—almost as soon as play commenced. No conversion followed. Next Krige dropped a very fine goal, and before half-time was taken, Bekker put on three points by dodging over the line when the opposition expected to see him swing the ball out. Neser was also a try getter, and the interval found our total points 13 to Catford's nil.

It seemed that Hirschberg was a little uncertain about receiving his passes in the second half, but practice will improve this. As a whole, Guy's were now combining much better, and they began to play less scrappily. Among the forwards one could always spot A. H. Shelswell. He played well, and so did Taylor and Neser. Some of the newcomers require training; too much extra weight was apparent. Both halves played well; Van Schalkwijk was in very happy mood. Graham-Davies greatly distinguished himself; his try in the second half a real gem, and so was his work when Hirschberg gained his second try. J. A. Krige, playing a clever neat game as usual, gained a try in this latter half. Before the final whistle blew a great run by Van Schalkwijk gave Bekker a clear run over the line. All these four tries were converted, Guy's finishing therefore with a lead of 5 goals (1 dropped) 3 tries to nothing, 33 pts. to nil. Our defensive play was better than the attacking side of the question. Crisp at full back was excellent.

As soon as the side settles down and one or two wanderers return, the Hospital will be represented by a XV. as good as any of its predecessors.

Guy's Team.—E. J. Crisp, R. Hirschberg, J. A. Krige, H. Graham-Davies, A. Daneel, F. Bekker, J. G. Van Schalkwijk, R. F. H. Duncan, E. E. Neser, W. H. Taylor, A. H. Shelswell, F. J. Biddle, G. G. T. Tregarthen, J. Maree, J. W. Schabort.

GUY'S v. COVENTRY.

The Hospital journeyed down to Coventry and gained a most meritorious victory. True, the margin was but one point, but we got three tries to our opponents' two, one of which was converted. Hence the nfial score was 9 points to 8.

We were without Doherty, Shelswell, Steyn, and Albertijn. L. B. Helder and L. K. Watson came into the forwards, in place of Shelswell and Schabort. the former not being able to make the journey. His valuable help was missed, still the remaining eight did exceedingly well, Duncan and Neser being perhaps the best. Quite early in the game we got a couple of tries. Neser was the first to score, and was followed by Hirschberg—both good efforts, but no conversion followed in either case. Coventry put tremendous energy into their play after this, and until half-time the home forwards were attacking. W. H. Morriss, a forward, gained a try and Pemberton gave a pass to Baker, who ran over for Morriss to kick a very fine goal. Had not our defence been very strong, the line would have been crossed more often. Crisp, Graham-Davies, and Bekker were extremely sound.

On resuming, the Hospital pack stuck most gamely to their task, and their efforts enabled the three-quarters and back division to show to much advantage. A great deal of really clever play was at last rewarded wtih success, Daneel gaining three points, which enabled the Hospital to claim the victory by the narrow margin stated above.

Guy's Team.—E. J. Crisp, A. Hirschberg, H. Graham-Davies, J. A. Krige, A. Daneel, F. Bekker, J. G. Van Schalkwijk, R. F. H. Duncan, E. E. Neser, W. H. Taylor, F. J. Biddle, G. G. T. Tregarthen, L. K. Watson, L. B. Helder, and J. Maree.

TEAS AFTER HOME MATCHES.

During the last two seasons it has been the custom for members to overcrowd the Pavilion after the matches at Honor Oak Park, and to occupy the tables available for nearly one hour following the close of play. Thus our visitors and players have often had to wait for a considerable time before obtaining tea.

In order that the players and the visiting team shall have the full use of the small available space in the Pavilion, the Committee have decided that only players, and a very limited number of members producing tea tickets, shall be allowed to enter the Pavilion after home matches during this winter.

Any member can obtain a ticket for tea from the Groundsman, at the Pavilion, before play commences, provided the limited number has not previously been sold.

FIXTURE CARDS.

These can be obtained upon application to the Secretary of the Association or Rugby Football Clubs, enclosing a stamped addressed envelope and a postal order for 1s.

Members at the Hospital can purchase Fixture Cards from any member of the Committee, or at the Students' Club Lodge, price 1s.

Correspondence.

Dear Mr. Editor,—I feel sure that the announcement of the forthcoming volume "General Bramble" will arouse a feeling of joyous anticipation in many Guy's women and men who have revelled in the author's "Les silences du Colonel Bramble," to my thinking the best of the lighter war books. It is strange that the new volume written by a Frenchman is being published in English before it has appeared in French. This can only be accounted for by the enormous success of its predecessor in the British Empire; yet like all such books the only way to enjoy it was to read it in the original. The author must have an unusual capacity for getting at the racial characteristics of his audience as well as an acutely keen sense of humour. With such targets as the conduct of the British Army in war and the British nation he has a splendid field for his wit, and yet one feels all the time his respects for the race which he chaffs and his affection for the particular specimens he depicts.

His acquaintance with England must have been wider than could be gained during the war else how did he hit on the following:—

"De les contrôler, Aurelle, soit, mais de les choisir, jamais! Une aristocratie ne peut pas être élue,: elle est, ou elle n'est pas. Comment? Si je prétendais choisir le commandant en chef ou le directeur de Guy's Hospital, on m'enfermerait; mais si je désire avoir une voix pour l'élection du chancelier de l'Echiquier ou du premier lord de l'Amirauté, je suis un bon citoyen!"

It would be very interesting to know whether Mons. André Maurois gained his information from some Guy's man who was M.O. to the unit with which he served as liaison officer or interpreter; perhaps one of our readers can enlighten us.—Yours very truly.

B. E. F.

Notice.

The photograph of the Guy's Hospital Nurses' Tennis Team, appearing on p. 379 of our last issue, was lent to us by the Sport and General Photographic Agency, and was published with the courteous permission of the Editor of the "Nursing Times," in whose journal it first appeared.

Specialities.

Concentrated Peptonised Cocoa & Milk.

Messrs. SAVORY & MOORE, Ltd., 143, New Bond Street, London, W. 1.

Concentrated Peptonised Cocoa and Milk, as prepared by Messrs. Savory & Moore, is an excellent invalid food from which a patient may derive a maximum amount of nourishment with a minimum of digestive effort.

It may therefore be recommended as a preparative of high nutritive value for those whose powers of assimilation are from one cause or another subnormal.

In cases of gastritis, indigestion, etc., this food will be found most helpful, whilst as a post-operative diet it would be difficult to suggest anything better.

It is a thoroughly good and reliable invalid food, and in this, as in others, Messrs. Savory & Moore maintain their reputation for the excellence of their preparations.

Medical men and nurses will be supplied with samples on application.

Kodak, Limited.

Those interested who have not yet made a trial of Eastman Dupli-Tized X-ray Film, will find it advantageous to do so, for this Film has been produced to give exceptionally fine results with a minimum of loss and waste.

Being coated with a Special Emulsion, advantage is claimed for it over the glass plates, not only in speed, but also in more simple methods of developing and fixing.

The Kodak Co. has on record many instances in which readable negatives have been obtained with one exposure on their Film not exceeding 1-6 of that given to glass plates without readable results.

The value of the Film for getting best results for X-ray work has been widely acknowledged, and this Company offers every facility for putting the merit of the Dupli-Tized Film to the test, and demonstrating the work that can be done with it. Radiologists who are not yet acquainted with it, will find it worth while to give this Film their attention.

Guy's Nurses' Tennis Club.

THE FAGGE CUP.

On August 26th the final match was played at the Nurses' Cottage, Honor Oak Park, for the Cup which was so kindly presented by Mrs. Fagge last year.

This year there was a great number of entries, and the final was well fought out by Nurses Vian and Stubbs, representing Cornelius and Astley Cooper wards, and ended after two exciting sets in a win for Nurse Vian, 6—4, 6—4. In the unavoidable absence of Mrs. Fagge the Cup was presented by the Matron, and a Tea Party in the Cottage grounds concluded a very popular competition.

The Secretaries of the Nurses' Tennis Club would like to take this opportunity of thanking the Secretary of the Clubs' Union for lending their ground to the Nurses during the time that the Court at the Cottage was under repair.

United Hospitals Hare and Hounds.

The opening run of the Cross-Country Season will be held from the "Green Man," Blackheath, next Wednesday, October 5th, at 3.30 p.m. Frequent trains run from London Bridge (S.E. & C.R.) to Lewisham Junction, which is ten minutes walk from the "Green Man." The five-mile run, which will be very little faster than a walk, will be followed by the Annual General Meeting.

Papers by Guy's Men.

C. H. Fagge, F.R.C.S. Circumcision.—*Clinical Journal*, L., 1921, p. 593.

Births.

COX.—On September 11th, at 21, Cornwall Gardens, Preston Park, Brighton, to Dr. and Mrs. A. Neville Cox, a son.

GRACE.—On Sept. 14th, at 66, Gloucester Crescent, Regent's Park, to Marjorie, wife of W. H. Grace, a son.

LONG—On September 5th, 1921, at "Chedworth," Orleans Road, Hornsey Lane, Highgate, N., to Violet (née Hook), the wife of Harold O. Long, L.R.C.P.Lond., M.R.C.S.Eng., a son.

Marriage.

GLASSINGTON—JAMES.—At Llangwne Church, Pembrokeshire, on September 14th, 1921, Charles Glassington, L.D.S. Eng., youngest son of Mr. J. H. Glassington, L.D.S. Eng., of Croydon, to Alice May, third daughter of Mr. A. H. James, of Guildford," Llangwne.

Death.

FELIX-JONES.—On September 20th, 1921, at Guy's Hospital, London, S.E., following an operation, Ada Louisa, the beloved wife of Dr. Felix-Jones, Llanfyllin.

The Sciences.

BIOLOGY.

The Biology course is primarily intended to be the students' introduction to the science of medicine, and must be regarded as the study of living things in many forms and from various aspects rather than the accumulation of facts about a number of plants and animals. In other words, it is intended as a training in the acquisition of a point of view rather than a stock of facts. Incidentally, also, the student learns a language which is largely his means of expression afterwards. The practice of the Biological Laboratory should give him a facility in the use of scalpel and scissors and a knowledge of methods of preparation and staining of tissues which are the arts of the Dissecting Room and the Histological Laboratory. Lastly, a thorough acquaintance with the vertebrate types should be a great help to him in obtaining an intelligent knowledge of human anatomy.

Cases of instruments are placed on view which include all those afterwards required in the Dissecting Room. A microscope is needed from the beginning, and the student is warned against buying an instrument which will be a handicap to him throughout his career. The difference in price between a good and a bad instrument is only a few pounds. All second-hand microscopes should be submitted to the Demonstrators for inspection and examination of lenses before the purchase is completed.

CHEMISTRY AND PHYSICS.

The student is often tempted to regard the study of Chemistry and Physics as one of very little use when once his preliminary examination is passed; but he will find in his study of the sciences of Physiology, Pharmacology and Pathology that a proper understanding of Chemistry and Physics is invaluable and essential. That this is so, is now fully recognised in the curriculum of the London University which should be carefully studied by every London student.

The matriculated student will, in his first year, study Inorganic Chemistry, Physics, and General Biology, and at the end of this period, provided he has worked diligently in the laboratories, and attended the lectures and revision classes regularly, should have no difficulty in passing the First Examination for Medical Degrees. In his second year he will study Organic and Applied Chemistry, together with Anatomy and Physiology, and at the end of the second winter, provided, as before, that he has worked steadily from the commencement, should have little difficulty in passing the First Part of the Second Examination for Medical Degrees. Anatomy, Physiology, and Pharmacology are then taken as the Second Part of this Examination, at the close of the third winter, prior to commencing clinical work in the wards.

From the Conjoint and the Dental student only six months' work is required. but those entering without previous knowledge of Chemistry and Physics will find that time hardly sufficient, and are usually advised to take the full "year" of three terms, or nine months.

The importance of practical work cannot be too greatly emphasised, and lectures and books can but supplement work done in the laboratory. Guy's men have no excuse for neglecting laboratory work. The Chemical Laboratory, for example, is open from 9 a.m. to 5 p.m. from Monday to Friday, and from 9 to 1 on Saturday, and students are strongly urged to form early the habit of spending their spare hours, apart from those officially allotted, in one or other of the laboratories. Reading should be left for the evening. After a day in the laboratory, reading a good text-book will be found to give ample scope for thought. "Cramming," or the memorising of words and phrases, without a knowledge of the corresponding realities, is one of the worst intellectual habits a student can acquire, and in the long run invariably leads to failure.

ANATOMY.

The primary object of dissecting is to render oneself familiar with the structures of human anatomy and their relationships one to another. A good knowledge of human anatomy is essential to the medical student, owing to the great scope for application of this knowledge which is provided by medicine and surgery, and it is no exaggeration to say that the better a man knows his anatomy, the more likely is he to succeed in either of these subjects. By handling and tracing the structures exposed in dissections, the student is enabled to form mental pictures which greatly exceed in value the plates and diagrams to be found in books, and it cannot be emphasised too much that the knowledge obtained by dissecting is more thorough, more lasting and more definite than the knowledge obtained from text-books, however good the latter may be.

In addition, dissecting trains the fingers and develops the sense of touch, and that delicate muscle sense which is so necessary to aid the eye in carrying out a delicate manipulation.

The basis of anatomical knowledge is a thorough acquaintance with the bones. These can only be learnt by handling the bone and making out each point on it as the description in the book is being read. Hence it is very desirable to possess a half skeleton. (This may be had from Mr. Hancock, the Senior Assistant in the Anatomical Department, who will also supply cases of instruments.)

The man who sits in an easy chair with an open Gray upon his knees and no bones by his side is simply wasting his time.

Men who intend to take the Primary Examination for the Fellowship of the Royal College of Surgeons should attend both the course of lectures for senior students in the second winter session (for times, *vide* notices), and also the special class for the Primary Examination.

Books and Instruments.

The student requires a Manual of Practical Anatomy, in which the structures are described as they are exposed in the course of dissection. The best book for this purpose is Cunningham's Practical Anatomy (3 vols., 12/6 each); it should be read before during, and after each day's work.

In addition, a text-book of Human Anatomy, in which the subject is described by systems, is neces-

sary. Gray's or Cunningham's Text-Book are both good.

Men who think that they may want to take the Primary Examination for the Fellowship of the Royal College of Surgeons will require a book dealing with Embryology and Morphology, and they will find that Keith's book on the subject contains all that is essential.

The following instruments are necessary:—Three scalpels, two pairs of *dissecting* forceps, and two sets of "hooks." No other instruments are necessary.

Dental Students.

The detailed knowledge which is demanded of the medical student is essential for the dental student only as regards the head and neck and the bones of the skull. Special demonstrations are arranged each term suitable to the requirements for the L.D.S. Examination. Dental students should arrange their curriculum in such a way that the three terms which they are required to spend in the dissecting room are consecutive. The disadvantages of breaking up the course are very obvious, and quite outweigh any apparent temporary advantage that may accrue from doing so.

PHYSIOLOGY.

Physiology, which forms the basis upon which scientific medicine and surgery rest, will require the most earnest attention on the part of the student during the short space of two years which he can devote to it, and he will find that his understanding of the medical, surgical and pathological problems with which he will meet later on varies directly with the thoroughness of his physiological ground work. While the reading of some elementary work on the subject, such as Huxley's *Elementary Lessons in Physiology*, or the smaller works by B. Moore and by Foster and Shore, during the first year is undoubtedly useful, yet for most men the practical study of Physiology begins in the first summer session. During this session he attends the classes in Practical Histology which are held three times a week, and for which he will need a microscope, certain mounting materials, and Schäfer's *Essentials of Histology*, which should be carefully studied.

The student should attend the lectures on Physiology (for times, *vide* notices), and also the tutorial classes which are held by the demonstrators. During this time he should read the subject in some text-book such as Starling's *Principles of Human Physiology*, Halliburton's *Handbook of Physiology*, Stewart's *Manual of Physiology*, Howell's *Text-book of Physiology*, or Hill and Flack's *Text-book*. While attending the practical classes held during the winter, the student is advised to read *Practical Physiology* (published by Arnold).

Physiological clinical demonstrations for senior students are held each week.

Candidates for the M.B. of London or other Universities must in addition attend the class in advanced practical physiology held twice a week during the second winter session, and this class should also be attended by men working for the first F.R.C.S. examination.

Those desirous of obtaining a wider knowledge or distinction in the second M.B. examination should supplement the course of reading indicated above with original papers in the *Journal of Physiology*, with parts of Schäfer's *Text-book of Physiology*, *Recent Advances in Physiology and Bio-Chemistry*, edited by L. Hill; *Further Advances in Physiology*, edited by L. Hill; *Principles of General Physiology*, by W. M. Bayliss; and Leathes' *Problems in Animal Metabolism*. Revision classes are held by the Demonstrators during the two months preceding the first F.R.C.S. and the M.B. examinations and should be attended by all candidates.

PATHOLOGY.

When the student has passed the Second Conjoint or M.B. Examination he is about half-way through his medical curriculum, and he should have gained a working knowledge of the functions of the body in health. This knowledge is an essential preliminary to the study of the most important of the medical Sciences, viz., Pathology, or the study of the functions of the body in disease. Throughout his life the student, if he continues to study and practise medicine, must ever keep pathology in the foreground. It is desirable, therefore, that the study of pathology be begun as soon as possible and continued throughout a medical career.

The subject is an exceedingly large one and it is customary to divide it into several sections:—

1. General Pathology.
2. Morbid Anatomy.
3. Morbid Histology.
4. Bacteriology.
5. Chemical Pathology.

Due attention must be paid to each of these branches.

During the first three months' work in the wards the study of pathology is commenced. Tuesday, Wednesday and Thursday mornings are occupied with lectures on the general principles of Pathology followed by practical work in Morbid Histology and Bacteriology. Regular attendance at these classes is most desirable, and the attractions of the Wards and clinical work should not be allowed to interfere with the laboratory studies.

Classes and demonstrations in chemical pathology should be attended during the tenure of the post of Medical Ward Clerk.

It is essential that throughout all ward appointments no opportunity should be missed of continuing the study of pathology. Every man should, as far as is practicable, follow out the pathology of each and every one of his cases. Is a bacteriological investigation made? He should follow it as far as possible. Is a portion of tissue removed for microscopical examination? He should see the section. Is a chemical examination demanded? He should try and see the analysis carried out. He should never miss an autopsy on any one of his cases. He should read up each case as he meets it. Set hours cannot be given for these lines of study, they must be fitted in as time and opportunity permit.

Efforts should be made to see as much practical work and as many demonstrations in pathology as can be arranged. There are very few days when no pathology can be learned. Post-mortems are held nearly every day — Monday, Tuesday, Wednesday, Thursday and Friday at 1.30 p.m., and Saturday at 11.30 p.m. Attendance at these will amply repay the time expended.

Informal classes in pathology are held three times weekly during the October and May terms (Tuesday and Thursday mornings and Wednesday afternoons). These, though primarily intended for M.B. students, are suitable for all, and should be attended by those sitting for Part I. of the M.B. Cantab. and the Final M.B. of Oxford or London University.

During the later clinical appointments certain students may hold a few pathological posts, such as Student Demonstrator, Assistant to the Demonstrators of Morbid Anatomy, Student Assistant in the Bacteriological Department, Section-Cutter. One or more of these may be held in turn, and they prove exceedingly valuable from the learners' point of view.

There are many books which might be recommended, and what suits one man does not prove attractive to another. MacCallum, "Text Book of Pathology"; Pembrey and Ritchie, "General Pathology"; with Muir and Ritchie, "Manual of Bacteriology," should prove an adequate combination for most purposes. Other books which may suit other tastes and which are good are—Adami, "Principles of Pathology"; Adami and Macrae, "Text-book of Pathology"; Green, "Pathology." For morbid histology Grunbaum "Essentials of Morbid Histology" may be recommended.

When the information in these books proves inadequate, as it is sure to do occasionally, some of the articles in Allbutt and Rolleston "System of Medicine" may be consulted, or references to original papers may be obtained from that work, and from the bibliography in MacCallum, "Text-book of Pathology."

BACTERIOLOGY.

From the preceding paragraphs it will be seen that elementary practical instruction forms part of the work of the newly appointed Ward Clerk, and as such is intimately associated with clinical medicine and surgery, on the one hand, and post-mortem study on the other. From the student's point of view microscopical pathology now occupies some 120 hours compressed into an appointment of three months' duration (Surgical Ward Clerk) instead of being extended over a period of six months, and more stress is laid upon the correlation of microbic activity and histological changes.

Bacteriology, although one of the youngest of the auxiliary sciences, has already made a most profound impression upon the theory and practice of both medicine and surgery, and by providing appropriate and specific treatment for bacterial infections has created the demand for exact as well as accurate diagnosis. Consequently, particular attention is devoted in this class to the technique of the various investigations undertaken in connection with the ward work. The student himself stains sputum, pus, and morbid exudates by various methods to demonstrate the associated bacteria. In addition, he is instructed in the practical work of culture and staining methods, and is encouraged to repeat for himself during the intervals between successive classes any observations and experiments previously carried out, in order that he may be adequately prepared to take advantage of the advanced courses which are available during later years of study, and to equip him for the performance in general practice of those more obvious methods of bacteriological diagnosis, which experience has shown are both reliable and valuable. Demonstrations are also given upon the life history of the various organisms pathogenic to the human race and the changes such organisms undergo or produce when they gain entrance to the human tissues.

During February and March of each year a course of lectures is given dealing more technically with the applications of bacteriology to practical diagnosis and treatment. These should be attended at a somewhat later period, since they deal with the various remedial agents (serums and vaccines) which have been elaborated in the bacteriological laboratory for the treatment of disease, together with those facts and theories relating to natural and acquired immunity upon which bacteriological therapy is based.

CLINICAL CHEMISTRY.

A class is held in this subject during the period of first three months medical ward clerk, forming part of the course in pathology. Students are recommended to make an early acquaintance with this subject in order that they may carry out investigations of this nature on their own cases, for which purpose accommodation is provided both in the clinical laboratory and in the laboratory of clinical chemistry.

MEDICAL WARDS.

To each medical ward clerk is allotted a certain number of beds, and he is expected to examine, and write full reports on all patients who are admitted into these. Occasionally it so happens that a patient is too ill to be examined except by the house-physician and physician, or that a case dies before the ward clerk has had an opportunity of seeing it. Under these circumstances he should obtain the history, and an account of the symptoms, physical signs, and progress of the case from the house-physician, and should base his report on these data. It cannot be too strongly insisted that a report, however brief, must be written on every case, and it is of the greatest importance that the diagnosis and remarks made by the Physician should be entered at once into the report. Moreover, any errors detected by the Physician or Registrar in the original report should be immediately corrected. In the event of a patient dying the ward clerk must obtain the abstract of the post-mortem findings, and carefully enter it up, and it need hardly be said that all clerks should make every effort to see the post-mortem examination on any case they may have seen during life.

The medical wards are open to clerks from 10 till 12.30 in the morning, and from 1.30 till 5.30 or 6 in the evening. The Registrars begin their rounds at 10.30, and by that time a clerk should at least have full notes of the history

of any new patient who may have been admitted into one of his beds; and he should have a full report in readiness for the Physician in the afternoon. Ward clerks should realise that they are expected to know the details not only of their own cases, but of every patient under their Physician. It is no excuse to plead ignorance because "this is not my case." If only a clerk will take the trouble to make himself conversant with each case in this way, he will find at the end of his six months that an enormous amount of clinical material has passed through his hands, and he will probably have acquired enough knowledge of medicine to enable him to pass the Conjoint Final with but little additional reading. But so many men waste their time through sheer laziness in the medical wards, never realising that they are throwing away experience which would prove invaluable to them later on.

An hour spent in the wards after tea three or four times a week will give opportunities, not only for going over cases and writing up reports, but also for seeing the house-physician tap chests and abdomens, etc. The treatment, too, which each case is receiving, may well be studied at this time.

As regards reading, the best method is to study the text-book account of each disease as one comes across it in the wards or in discussion, and afterwards to compare, if possible, the text-book description with the symptoms and signs presented by the patients. At the same time, the most important medical journals should be read regularly, for by this means only can the student keep himself in touch with modern work. The *B.M.J.* and *The Lancet*, *The Quarterly Journal of Medicine*, as well as the *Journal of the American Medical Association*, are especially recommended.

Books that may be recommended are the following:—The well-known text books by Taylor and Osler, "Medical Diagnosis," by Latham and Torrens (a most valuable work), and "Auscultation and Percussion," by Gee. For second three months ward clerks Dieulafoy's "Text-book of Medicine," the most important monographs in Allbutt's or Osler's "System of Medicine," and Campbell Thomson's "Diseases of the Nervous System," will prove valuable and interesting reading. For laboratory work Hutchinson and Rainey's "Clinical Methods," or Dr. French's book will be useful.

SURGICAL WARDS.

The appointment of Surgical Ward Clerk is held for three months. It is the first, and possibly the best, clinical appointment. The ward clerk has a very definite responsibility, not only in recording the history and progress of his cases for future reference, but also in making observations which may be of vital importance. In this way the knowledge he acquires is the more certainly impressed. Each clerk is attached to a surgical unit, and works in the wards under the direction of the surgeon to whom he is attached and the registrar of the unit.

During this appointment the student attends a course in elementary pathology and pharmacology, and receives a grounding in the principles of disease and treatment. At the same time he cannot be too strongly recommended to take every advantage of his opportunities to gain an insight into that practical work which will stand him in good stead, not only as a surgical dresser, but throughout his professional career. He should make a point of spending all his available time in the Surgery during "take in" week, and of seeing major and minor operations and even dressings whenever possible.

The responsibility of writing careful reports is too obvious to labour; no clerk with a grain of common sense will regard a surgical report merely as an educational exercise for his own benefit.

Two further periods of three months are devoted to the appointments of Surgical Dresser. The work of a dresser is perhaps of more importance at Guy's than at any other hospital, and the advantages to be gained are correspondingly greater. A dresser has only to realise this to prove himself worthy of the trust and reap the benefits.

The most junior clinical student has a definite status in the wards, and he will find his opinion as an anatomist or physiologist treated with the greatest respect. That he should occasionally be called upon to do some of the "dirty work" is inevitable; but no reflection is cast thereby on his standing.

We have only briefly indicated the main points in the work of a surgical dresser. He will receive a copy of the "Standing Orders" relative to this and each other appointment he may hold. The hospital expects, and rightly insists, that he shall pay strict attention to these orders, since he is no longer an irresponsible student, but for the time being one of the cogs in the wheel on whose integrity the smooth running of the hospital depends. With growing knowledge comes growing responsibility, and he must show himself worthy of the trust reposed in him.

THE OBSTETRIC DEPARTMENT.

After finishing appointments in the Medical and Surgical Wards the student is posted to the Obstetric Department for six months. During the whole of this period he is also attached to the Physician for Children's Diseases. The Obstetric Dresser is responsible for case-taking in the wards and at Out-Patients, assists at operations, and during one month acts as Extern in the Maternity Charity. The Department has twenty-two beds reserved for gynæcological cases and eleven beds for the reception of cases presenting complications in pregnancy, labour and the puerperium. As an intervening link between the Obstetric and Children's Departments is the Salomons Centre, in which the health of mothers and infants is fostered by the practice of preventive medicine. The scope of the work done outside the wards is indicated by the fact that last year 2,400 attendances were recorded at Obstetric Out-Patients, while 3,500 women were attended in confinements in their own homes.

With this wealth of clinical material available it should be possible for every student to obtain a sound knowledge of methods of diagnosis and treatment founded on no small experience. It must be confessed that this desideratum is not always attained and the cause lies partially in a fundamental defect in the medical curriculum. Passed through the

hands of a succession of specialists, the student is apt to develop a compartmental mind: the filling up of a buff transfer slip is all the consideration which he is prepared to give to a case with gynæcological symptoms. It cannot be too strongly urged that a wider outlook on Medicine should be cultivated, and that the study of the symptoms of diseases peculiar to women should be begun from the outset of a student's clinical training. The man entering the wards who hopes to become a complete doctor should include among his initial purchases a book on Gynæcology and should make a point of attending the systematic lectures given by the obstetric surgeons during the summer session. He should also avoid no opportunity of acquiring the "tactus eruditus" so essential to the diagnosis of pelvic disorders. The inherent impossibility of permitting a class of students to examine women one after another renders it imperative that this experience should be gained over a considerable period of time.

The study of midwifery he may well leave until he becomes an obstetric dresser, and it is hoped that in the near future he may be provided with still greater facilities for learning this art.

THE CHILDREN'S DEPARTMENT.

Physician-in-Charge, Dr. Cameron.

Chief Clinical Assistant, Mr. A. A. Osman.

In-patient accommodation.—Dr. Cameron has under his care 14 cots in the Children's Ward. On two days in the week, at present on Tuesdays and Thursdays at 2 p.m., Dr. Cameron goes round the ward and gives clinical instruction.

Out-Patient Department.—Children under 10 years of age are seen in the Children's Department at Out-Patients on Mondays, Wednesdays, and Fridays from 9.30 until 1 o'clock. Dr. Cameron attends on Mondays and Fridays at 10 a.m., when clinical instruction is given.

The Salomons Centre for the care of the mothers and children of the Midwifery Charity is now completed.

NEUROLOGICAL DEPARTMENT.

MEDICO-NEUROLOGICAL CLINIC.

The arrangements for the Medico-Neurological Clinic for the Winter Session are not finally settled, but they will be approximately as follows:—

(1) *Elementary Ward Teaching at 2 p.m.* Monday and Friday, Dr. Hurst; Thursday, Dr. Hunt; Tuesday, Dr. Symonds (Neurological).

(2) *Advanced Ward Teaching for post-graduates only at 10.30 a.m.* Tuesday, Dr. Hurst and Dr. Symonds; Thursday, Dr. Hurst and Dr. Hunt (Neurological).

(3) *Clinical Demonstrations at 12 noon.* Mondays, Medical, in turn, Dr. Hurst (gastro-intestinal), Dr. Hunt (circulatory), Dr. Marshall (tuberculosis), and Dr. Barber (dermatological); Wednesdays, *Neurological,* Dr. Symonds, 1st 3rd and 5th Wednesdays, Dr. Hurst, 2nd Wednesday, and Dr. Craig, 4th Wednesday; Fridays, *Medico-Surgical.* Dr. Hurst or Dr. Hunt with a surgeon or specialist.

(4) *Out-Patients.* Medical, Tuesday, Dr. Hunt; Neurological, Wednesday and Friday, Dr. Symonds.

THE DERMATOLOGICAL DEPARTMENT.

Out-Patient Days.—Tuesday, 10.30 a.m. (children), 1.30 p.m. (adults). Thursday. 9.30 a.m.

The Physician in charge of the Department also sees selected old cases, which require special investigation or treatment, on Wednesdays at 1.30 p.m., and anyone desiring to carry out a research in the Department may arrange with patients to attend at this time for the purpose of investigation.

Wards. There are three male and three female beds in the Medical Wards for dermatological cases requiring careful supervision or treatment in bed.

Instruction in the diagnosis and treatment of diseases of the skin is given in the Out-Patient Department, and clinical demonstrations on selected cases are held from time to time.

THE AURAL AND LARYNGOLOGICAL DEPARTMENT.

This Department is organised on the unit system. There are two units, one under the care of Mr. Mollison, the other of Mr. Layton. Patients are seen in the Out-Patient Department, admitted when necessary to the special wards, Ruth and Barnabas, and returned to the Out-Patient Department. This arrangement allows members of each unit to follow up the cases. Mr. Mollison's firm sees out-patients on Tuesdays and Fridays at 12 noon, Mr. Layton's firm on Mondays and Thursdays at 12 noon.

Dressers are appointed to the respective firms, and have every opportunity of becoming expert in the technique of examination of the ear, nose and throat, and gain experience in diagnosis and treatment. Large numbers of school children are seen, and about 1,000 minor operations are performed in the Out-Patient Department a year; of these the great majority are for the removal of tonsils and adenoids: these operations are performed by the dressers under the supervision of the Surgeon or the Clinical Assistant.

Eighteen beds are now allotted to the Department and each firm operates twice a week. Mr. Mollison and Mr. Layton "take-in" during alternate weeks and emergencies are admitted under the care of the firm on duty.

THE OPHTHALMIC DEPARTMENT.

The Ophthalmic Department of the Hospital is in charge of the two Ophthalmic Surgeons. They are helped by two Assistants, two House Surgeons and Dressers. The dressers are appointed four times a year

for a period of three months, and assist the Surgeons at Out-Patients and at operations, and are responsible for the recording of the cases both in the wards and at Out-Patients. The Ophthalmic Department is an open field for any student to explore as far as he is willing and able, the amount of clinical work being sufficiently great for him to see all the more ordinary and common diseases of the eye in the space of three months.

The student will soon find that he is quite unable to form any opinion of his own, on an ophthalmic case, until he has mastered the use of the ophthalmoscope and can readily and accurately decide what is the refraction of the eye, and if the "fundus oculi" is healthy and normal. The theory of retinoscopy can be taught and is simple; the practice, however, requires constant application by the student before he can hope to obtain any sort of facility in it. The difficulties are mainly initial ones, and any time and trouble expended in mastering them will well repay any man in after life when he has qualified and is in practice.

The Ophthalmic House Surgeoncy is one of the most important in the Hospital, as the Ophthalmic House Surgeon is not only in charge of the Ophthalmic beds, but also of Ear, Nose, Throat, and Orthopædic beds, so that his experience is wide and his responsibility great.

THE ORTHOPÆDIC DEPARTMENT.

The Orthopædic Department comprises a large out-patient clinic and ten beds devoted to patients suffering from deformity. Out-patients are seen on Monday and Wednesday afternoons, and in the Out-Patient Department the student will meet with every variety of deformity, congenital and acquired. Considerable facilities are afforded for experience in the relief and cure of all chronic diseases of bones, joints, muscles, etc. Instruction in the principles and most modern practice in the use of appliances, plaster technique, and the more useful forms of physio-therapy is given by Mr. Trethowan, the Orthopædic Surgeon, and Mr. Todd, the Orthopædic Registrar. Numerous operations of a minor nature are done, such as manipulations for stiff and painful joints, correction of mis-shapen and ricketty limbs, correction of scoliosis, and immobilisation of tuberculous joints.

The in-patient beds are devoted to the most serious operative cases, such as extensive tendon transplantations, correction of mal-united fractures, bone-grafting, the making of new joints, etc. Guy's is a pioneer in possessing an excellent workshop for the manufacture of every form of splint and appliance.

It is in the Orthopædic Department that the principles underlying the mechanical disabilities of the limbs and spine are emphasised and their explanation made clear, and the experience to be gained here is invaluable. The great utility of orthopædic surgery has become evident to very many during the war, and the extensive orthopædic administration now devoted to the care of pensioners will almost certainly merge into some big national scheme for the care of vast numbers of crippled children.

THE GENITO-URINARY DEPARTMENT.

Students acting as Dressers in this Department have excellent opportunities of acquiring knowledge which will be useful to them in actual practice and examinations. Out-patients are seen on Tuesday and Friday afternoons.

There are nine in-patient beds, seven in Cornelius Ward and two in Queen Ward. During the past year attention has been paid in particular to congenital abnormalities of the lower urinary tract, and it is hoped that some progress has been made in the treatment of these important and distressing conditions. Students should realise that their attendance at this out-patient department, though not compulsory, is very necessary, as is evidenced by the very advanced state of disease in which some patients arrive for examination.

THE MASSAGE DEPARTMENT.

The New Department is now in full working order, and patients are treated between the hours of 2.30 p.m. and 4.30 p.m. on Mondays, Tuesdays, Thursdays and Fridays, and between 9.30 a.m. and 12 a.m. on Wednesdays and Saturdays.

Clinical Demonstrations are given at 2.30 p.m. on Mondays by Dr. Hunt, Physician in Charge, and at 10 a.m. on Wednesdays and Saturdays by Mr. Trethowan, Surgeon in Charge.

The point of interest to Medical Students is to see the work carried out on Patients by Massage and Medical Gymnastics. A large variety of cases are being treated daily which include fractures, stiff joints, dislocations, nerve injuries and disease, lung and heart disease, congenital conditions, and poor development in Children, &c. Students will find interest in following some investigations which are being carried out under the direction of Dr. Hunt, and those who wish to attend in this section of the Hospital should apply to him.

THE TUBERCULOSIS DEPARTMENT.

(Dr. Marshall).

The Tuberculosis Department is a reference department for out-patients suffering from disease of the chest. Patients attend on three days in the week, Tuesday and Friday afternoons and Wednesday evenings. In suitable cases arrangements are made for admission to sanatoria. The patients return to the Out-Patient Department after leaving the sanatorium. The Department provides extensive opportunities for studying methods of investigating early and doubtful cases of pulmonary tuberculosis, also for observing special forms of treatment such as Artificial Pneumothorax.

PRACTICAL PHARMACY, MATERIA MEDICA, AND DISPENSING.

One of the many important things all medical students must know is how to write a prescription; it may even be necessary for the majority, when

qualified, to know how to dispense the same, so that the student will do well not to neglect acquiring as much knowledge of this subject as he can.

The student is taught practically the methods of prescribing, he practises writing prescriptions for combinations of drugs with due regard to incompatibility, and he is taught how to dispense the prescriptions he has himself written.

The course covers the syllabus of the Practical Pharmacy of the Conjoint, the Intermediate M.B. Lond., and the Third M.B. Cantab.

DENTAL SCHOOL.

The Dental Student is supplied at the Medical School Office with the Prospectus, Standing Orders, List of Instruments, Calendar, and Clubs' Union Book.

These pamphlets should be carefully read in order that acquaintance may be made with the general arrangements of the school and the scope of the work upon which the student will become engaged.

Notices regarding the time and place of Lectures are to be found posted up at the main entrance of the Dental Department.

Instruments having been purchased at a dental depôt, the student should satisfy himself that he has been supplied with all of those described in the hospital list.

First and second year students need only those instruments necessary for Prosthetic work, and are advised not to purchase instruments used during their clinical period of study (third and fourth years) until the commencement of the third year.

Among the various depôts at which instruments may be purchased are the following :—Claudius Ash, Sons & Co., Broad Street, Golden Square, W.C. ; Dental Manufacturing Co., Alston House, Newman Street, W.; and Cottrell & Co., 15, Charlotte Street, W. 1.

First and second year students have a simple routine to follow. Their work is confined chiefly to Dental Prosthetics, but Chemistry and Physics and Dental Metallurgy are also studied and should be passed, the first two subjects during the first year the third during the second year.

The student will come into actual contact with Hospital patients during his second year, and he should always endeavour to be punctual in his appointments with them. There is nothing more irritating and annoying to a patient than to be kept waiting unnecessarily; it also delays to a very great extent the easy working of the Department. Further, the student should remember that the cultivation of a courteous and gentle manner towards his patients will become in the future probably the greatest asset in his private practice.

Third and fourth year students commence their clinical courses with a two months' period of probationary work upon the phantom head. This operative course, conducted by a staff demonstrator, is very comprehensive. It includes most of the conservative operations that the student will subsequently be called upon to perform upon patients, namely, gold and other fillings, crowns, inlays, and the treatment of devitalized and septic teeth. These operations upon the dummy form an excellent ground work in operative dentistry.

Thereafter the course of work consists in holding and diligently carrying out the work of the following appointments:—*Probationary Dressership in the Conservation Room; *Dressership in the Conservation Room; *Dressership in the Children's Department; Dressership in the Ordinary Extraction Room; Dressership in the Gas Extraction Room; Casualty Dressership; Clerk to Anæsthetist.

A student, apart from those holding the post of Assistant Dental House Surgeon or Clinical Assistant, and men up for Part II. of the Final Examination for the L.D.S., is not allowed to work in the Conservation Room unless he holds one of the appointments marked *.

Dental students will profit by following the practice of the Special Departments of the Hospital, *e.g.*, Eye, Throat, Ear. They will also have numerous opportunities of observing the more remote effects of dental disorders in the General Wards and Out-Patient Department.

Students in difficulties about their work and needing advice are invited to consult the Dean, Sub-Dean, Resident Dental Officer, or any other member of the Staff, who will be pleased to do what they can to promote the interests of students.

OSTEOLOGY.

The question of the purchase of bones is always an important one. Millikin & Lawley, in the Strand, make a speciality of supplying the medical student with this part of his equipment.

BOOKS.

The student who wishes to obtain his books at once should not take the first he sees on any particular subject, but would be wise to consult his demonstrators first. The number of text books is very large, and the choice is a difficult matter to the inexperienced. Roughly speaking, second-hand books are very seldom worth anyone's while to buy, chiefly because medical science is progressing so rapidly that new editions are constantly being published.

The number of publishers of books for medical students is great. Messrs. Churchill publish Taylor, Jacobson, Goodhart, Fagge, and many other well-known works. Messrs. Macmillan publish Allbutt, Foster, and a great number of first-year books; Messrs. Longmans, Green & Co., publish the famous Gray's Anatomy. Mr. H. K. Lewis, 136, Gower Street, publishes a number of medical books, and has also a medical circulating library which is valuable to students who wish to see all the latest books. Mr. Murray also publishes many well-known medical books, as also do Smith, Elder & Co., Philip & Son, Cassell & Co., Nisbet & Co., and Baillière Tindall & Cox.

All books can be obtained from Mr. H. H. Grattan, in Borough High Street, who is the "official bookseller" to the Hospital. Many well-known books he can supply over the counter; any others desired he will have in an hour or two.

ED.—A. T. R.

GUY'S HOSPITAL GAZETTE.

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Passim.

BY an unfortunate co-incidence the two chief functions of the Medical and Dental Schools which took place during the last fortnight, happened to clash the one with the other. We found ourselves having to choose on Thursday last between rival attractions in the Anatomical and the Physiological Theatres. In the one an interested audience listened while Dr. Vincenzo Guerini, of the University of Naples, lectured on and demonstrated some "Appliances for the Correction of Facial Deformities," while in the other the new session of the Physical Society was being inaugurated by Sir Alfred Fripp. We decided in the end to go to this latter meeting (largely because we knew from experience that the seats were more comfortable here), and our attendance was amply repaid. The Senior Surgeon was in his happiest mood, he kept us laughing throughout his discourse and sent us away full of wise saws and most enthusiastic for the new session.

IN our correspondence this week, we have two more letters upon the Milk Question, one of which condemns us in scathing terms for the "sentimental" attitude we took up in protesting against the cutting down of the grant for milk. We let Dr. Cameron's letter pass last week without comment, but we feel that in response to this fresh letter we must make our position clear. We are entirely in agreement with Dr. Cameron in condemning artificial feeding of babies. We could hardly be otherwise, for it is to Dr. Cameron that we owe our training in all matters which concern children. But we do firmly believe that the extra food which has been given out to nursing mothers is both valuable and welcome to them. The fact that babies did not do badly when their mothers were starved, as Dr. Cameron and Miss Paterson have pointed out, has very little to do with the argument. Our concern must not be only for the babies, but for the mothers also. Dr. Cameron tells us nothing of the effect of the extra strain of suckling upon these poor starving mothers. Surely he will agree that although the child may not be appreciably better in its health and growth, yet the mother must profit by this extra nourishment.

THE Superintendent has forwarded to us an interesting document which was sent to his office by the Commissioner of the Royal Canadian Mounted Police. This is a copy of the Free Pardon which was granted by Order in Council to Dr. W. K. McKay for his desertion from the Royal North West Mounted Police. As our readers will remember, it was mentioned in Dr. McKay's obituary notice that he deserted

from the Police, and, after many adventures, reached England and enlisted in the Army. On account of his war services he was recommended for free pardon, and he received this early in 1920.

We have heard, with deep regret, of the sudden death of Hugh Thomas Symes Bell, who was at Guy's in the nineties. He left England after having obtained the Fellowship of the College of Surgeons, and went to Brisbane, where he was for a time Resident Medical Officer at the Hospital for Sick Children. He died on July 23rd last, from pneumonia, at his home in Sydney. We feel sure that all his contemporaries will join with us in offering sincere condolences to his widow.

We came across a paragraph in a Sunday paper a week back which should interest Guy's men. This paper (*The Referee*) had been carrying on a discussion in its columns as to which was the oldest surviving Rugby Football Club. Claims had been forwarded for Blackheath, Clifton, the Wasps, and many other teams, but all of them have had in the end to give place to Guy's. For Dr. R. M. Henry Randell, who captained the Guy's XV. in 1883–84, was able to prove by the aid of old fixture cards that our XV. unquestionably began its successful career in 1843–44, and is much older than is any one of these other clubs.

We have to thank, firstly, Dr. Randell for being so rightfully jealous of the Hospitals' reputation, and, secondly, the Rugby correspondent of the *Referee* for his courteous article and his good wishes to the Guy's XV. in this, their seventy-eighth season.

Dr. Hurst is restarting the Medico-Neurological clinic which proved so successful last year. As was the case last year, there will be, in addition to lectures and demonstrations on purely medical and neurological subjects, a series of combined demonstrations, which will be given by Dr. Hurst and one of the Surgeons, or one of the specialists. These will touch upon the border-line subjects which come partly into the province of the physician and partly into the more restricted sphere of work of the specialist. We hope that Dr. Hurst will not discontinue the practice, which he initiated in his last session, of getting general practitioners and others, who were not closely connected with the Hospital, to come and talk to us here.

A synopsis of the scheme which has been arranged will be found on page 421. Most of the demonstrations are (it will be seen) at what has been found the most convenient hour for the majority of men, namely 12 noon. We can confidently assure Dr. Hurst of the enthusiastic support of all men in the wards, in the carrying out of his ambitious programme.

Before our next Gazette appears, the Biennial Dinner will have been held. There is still time to send in your name, and you are earnestly asked to read Mr. Ormond's letter and his revised list of acceptances, which you will find on page 416, before you definitely say that you are not coming. We feel, that having read this letter and list, you will not make such a foolish refusal.

Interesting Cases in the Wards.

Under Dr. Fawcett, Dr. Ryle and Dr. Marshall.

Stephen	26.	Interstitial nephritis, cirrhosis of liver, gout.
	45.	Pyloric obstruction and pyelitis.

Under Dr. Beddard and Dr. Mutch.

Stephen	3.	Hodgkin's disease.
	16.	Carcinoma of stomach.

Cases under Dr. Hurst, and Dr. Hunt.

Addison	9.	Aortic endocarditis.
	10.	? Cerebral syphilis.
	11.	Pernicious anæmia.
Mary	38.	Addison's disease.

Pointing the Obvious.

By a Thirty-Second Year Man.

"The extremities, or limbs, are those long jointed appendages which are connected to the trunk by one end, and are free in the rest of their extent."—*Gray's Anatomy.*

The anatomical mind is capable of some strange freaks. I know that this is not confined only to anatomical minds, but to those unfortunate people to whom anatomy is a thing to be learnt patiently, and not an orgy of intuitively acquired facts. Gray's lighter moods are oases in a desert of the strictly ordinary. I cannot believe that even an anatomist could pen in all due seriousness such lines as head this article.

One can imagine him stolidly describing some organ or other. "The first part runs in such and such a direction, and is four inches long: the second part is a little shorter, being only three and a half inches, making altogether seven and a half." The point of the joke lies in the last six words. Facts have grown too much for him; he must come down from his Olympian height, and so he writes, "Making altogether seven and a half," and bubbles over with delight at his wit.

As a matter of fact, though, anatomists are not alone in this delicious use of the irony of the obvious; physiologists also descend occasionally to similar delicate quips, and I seem to remember tyrant-authors of my schooldays indulging as well. But a great fear possesses me. Supposing—supposing Mr. Gray meant every word he wrote to be taken seriously! The possibility appals me! Had Mr. Gray ever owed allegiance to Gilbert's "Mikado," he doubtless would have been instantly condemned to be a proof-reader to some of the more frivolous magazines.

Papers by Guy's Men.

E. B. Dowsett, D.S.O., M.R.C.S., L.R.C.P., L.D.S. Consideration for our Patients.—*Dental Record*, LXI., 1921, p. 521.

Sir W. Arbuthnot Lane, M.S., F.R.C.S. The Disastrous Results of Certain Abduction Fractures of the Ankle Joint.—*Lancet*, October 1st, 1921, p. 697.

Philip Turner, M.S. Case of Cystic Tumour of the Cheek.—Proc. Roy. Soc. Med., XIV., 1921, Clinical Section, p. 76.

Grant Massie. Fibrocystic Disease of the Skull.—*Ibid.*, p. 76.

W. H. Ogilvie, M.Ch. (1) Case of Parovarian Cyst in a Baby aged 3 months.—*Ibid.*, p. 77.

(2) Case of Multiple Brodie's Abscesses in the Scapula.—*Ibid.*, p. 78.

A. W. Sheen, C.B.E., M.S., F.R.C.S. Case of Abdominal Tumour.—*Ibid.*, p. 79.

R. P. Rowlands, M.S. (1) Case of Gastro-jejunal Ulcer.—*Ibid.*, p. 82.

(2) Case of Jejunal Ulcer, p. 82.

W. H. Jewell, O.B.E., M.D. Thyro-glossal Cyst.—*Ibid.*, Sec. of Laryngology, p. 69.

W. Kelsey Fry, M.C., M.R.C.S., L.R.C.P., L.D.S. The Dental Aspect of the Treatment of Congenital Cleft Palates.—*Ibid.*, Sec. of Odontology, p. 57.

H. W. Barber, M.A., M.B., M.R.C.P. Discussion on Cutaneous Sensitization and Focal Sepsis in the Etiology of Skin Affections.—*Brit. Med. Journal*, October 8th, 1921, p. 554.

Neurological Department.

The account of the Neurological Clinic, published on page 410 of our last issue, contains several errors which had unfortunately been overlooked.

The following are the corrected details:—

Dr. Symonds goes round his beds in the wards on Mondays at 2 p.m.

Dr. Symonds' Out-Patients.—Wednesday and Saturday, from 9.30 a.m. to 1 p.m.

Dr. Symonds' Clinical Demonstrations on Cases of Nervous Disease.—Alternate Fridays at 12 noon, beginning on October 14th.

Change of Address.

J. H. Jones, 90, Earlham Road, Norwich.

Dr. Frederic Vicars, 18, Alwyne Mansions, Wimbledon, W. 19.

V. E. Lloyd, M.C., M.B., B.S., M.R.C.S., L.R.C.P., 75, Wimpole Street, W. (Telep. Langham 2755.)

S. T. Wong, 3, Caine Road, Hong Kong, China.

Publications Received.

Journal of R.A.M.C., Nursing Times, New Zealand Journal of Health and Hospitals, Romance of Modern Medical Missions, Middlesex Hospital Journal, The Prescriber, St. Bartholomew's Hospital Journal.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

THE BIENNIAL DINNER.

Wednesday, October 26th, 1921.

DEAR MR. EDITOR,—I am sending you the list of those who have so far signified their intention to be present at the Dinner. Tickets are being sent to all those whose names appear in the accompanying list.

By far the greater number of men have already notified me near whom they would like to sit—and this has greatly facilitated the arrangements—but I would ask any one who has not done so to return to me immediately the notice accompanying the ticket as therein requested.

If this is done I hope to be able to arrange that each diner will find himself seated among his own particular group of friends. On the other hand, it will be impossible for me to carry this satisfactorily into effect in the case of those whose replies reach me later than the evening of Wednesday, October 19.

Of course if there are any Guy's men who have been unable so far to decide to come, and yet find that at the last they can do so; or if there are any who, on looking over the accompanying list see names which induce them to come, I hope that they will apply to me *at once* for a seat, informing me in the letter near whom they would like to sit. I will then do the best I can for these late comers who though late in applying, will be none the less welcome.—I am, Sir, Your sincerely,

ARTHUR W. ORMOND,
7, Devonshire Place, W. Hon. Sec.

LIST OF GUY'S MEN WHO HAVE SIGNIFIED THEIR INTENTION TO ATTEND THE DINNER.

1869—1879

1869†Durham, F.
Reynolds, John
1870 Burroughes, J. E. B.
1875 Brown, Thomas
Elcum, D.
Symonds, Sir Charters J., K.B.E., C.B.
1877 Lane, Sir Wm. Arbuthnot, Bt., C.B.
Mansell, E. R.
1878*Beale, E. Clifford
Leigh, W. W.
1879 Hale-White, Sir Wm., K.B.E.
Howell, T. A. I.

1880—1889

1880*Ashwell, H. G., O.B.E.
Newnham, W. H. C.
1881 Pitt, G. Newton, O.B.E.
Shaw, L. E.
1882 Gibson, J. H.
Worthington, S.
1883 Jago, C. S.
Jones, M. Parry
*Meyer, Col. C. H. L.
Wright, H. H.
1884 Counsell, H. E.
Muspratt, C. D.
Randall, R. M. H.
Tubby, A. H., C.B., C.M.G.
1885 Andrews, E. C.
Price, A. E.
1886 Greenwood, E. C.
Sandoe, J. W.
1887 Bisshopp, F. R.
Brownfield, H. M.
Holloway, S. F.
1888 Bellingham-Smith, C.
Collington, F. A.
Holman, F. K.
Marriott, H. B.
Pennel, G. H.
Randall, P. N.
*Roberts, Astley C.
Robertson, J.
1889 Black, George
*Fripp, Sir Alfred, K.C.V.O., C.B.
Lansdown, R. G. P.
Price Jones, C.
Rouw, R. W.

1890—1899

1890 Fawcett, John
Pilcher, Col. E. M., C.B., C.B.E., D.S.O.
Spurrell, C.
Stevens, T. G.
*Swayne, F. G.
Thorne, J. M.
1891 Craig, Sir Maurice Hopson
Montagu Jewell, J. W. F.
Pollock, Col. C. E. C.B., C.B.E., D.S.O.
1892 Birdwood, G. T.
Carling, W.
Daldy, A. M.
*Fisher, W. H.
Godson, A. H.
Young, F. C.
1893 Eyre, John
Hovenden, A. C.
Jewell, W. H.
Meyrick-Jones, H. M.
Keay, Colin
Parfitt, J. B.
1894 Allport, A.
Brereton, F.
Carpmael, C. E.
Cooper, H.
Duffett, H. A.
Hovenden, G. S.
Phillips, R. E. G.
Reynolds, B. G.
Robinson, W. E.
*Steward, F. J.
1895 Beadnell, C. M.
Beddard, A. P.
Collier, H. W.
Ensor, G. A.
Gwynn, Lt.-Col. W. P. C.M.G.
Handley, W. F.
Partridge, A. H.
Shorland, E. T.
Stewart, H. M.
1896 Brice-Poole, T.
Delbruck, R. E.
*Edwards, C. D., M.C.
Fagge, C. H.
Harris, W. O. W.
Hincnliff, C. J.
Howell, J.
Knowles, C. H.
Millbank-Smith, H. J.
Reed, J. C. G.
Robertson, James
Rowlands, R. P.
Stead, C. C.
Tilbury-Brown, Lt.-Col. R.
1897*Bruce, H. W.
Cloud, F. H. L.
East, W. N.
Evans, Col. C.R., D.S.O.
Fremantle, F., O.B.E., M.P.
Thornely, M. H.
Wakefield, C. F.
Watkins, J. P.
Way, M.
1898 Eason, H. L., C.B. C.M.G.
Henson, W. J.
McGavin, L.

Morgan, A. Kinsey, Junior.
Nicholson, C. R.
Owsley, G. Chetwode
Peatson, J. C. S.
*Rowlands, E. W. S.

1900—1909

1900 Aylen, G. H.
*Bagshawe, Col. H. V., C.B.E., D.S.O.
Brydone, J.
Butler, J. A.
Camps, P. W. L.
Corfe, E. W.
Forsyth, D.
French, H., C.B.E.
Goble, E. W.
1901 Atkins, Sir John, K.C.M.G.
Bent, S. C. H.
Coplans, M.
Glover, J. A.
Gray, Lt.-Col. A. C. H.
Greenfield, D. G.
Hardenberg, E. J. F.
Keates, H. C.
Pearson, Arthur.
Roper, Richard
1902 Osburn, Major A. C., D.S.O.
Pinching, C. J., O.B.E.
1903 Goldie, E. G.
Greeves, R. A.
Mann, H. C.
Wallace, F. H.
Swan, R. H. J., O.B.E.
Turner, Philip
1899*Dowsett, E. B., D.S.O.
Miller, A.
Nicholls, F. J.

1904 Cowper, C. M.
Hughes, E. C., O.B.E.
Hughes, F. R.
Hurst, A. F.
Leeming, A.
May, W. N.
Mollison, W. M., C.B.E.
Pollard, J.
Robinson, G. C. F.
Woodward, H. H. M.
1905*Bellingham-Smith, E.
Cameron, H. C.
Clarke, H. M.
Crofts, A. D.
McBride, J.
Payne, O. V.
Watney, H. A.
1906*Alcock, A.
Bankart, A. S. B.
Davies-Colley, R., C.M.G.
Fouché, F. P.
Goodhart, G.
Layton, T. B., D.S.O.
Malleson, H. C.
Ripman, C. H.
Stebbing, G. E.
Parsons, J. E. H.
Payne, J. L.
Pearce, Frank J.
Penrose, A. W.
*Rowlett, A. E.

1910—1919

1910 Barber, H. W.
Cox, Neville
Elliott, E. L.
Gardiner, H.
Hunt, G. H.
Kidd, W. S.
Maxted, G.
Marshall, G.
*Mullally, G. T., M.C.
Penny, E. A.
Poulton, E. P.
Rayner, A. E.
Reader, N. L. M.
Saner, F. D.
Thomson, G. Y.
1911 Billing, E.
Blake, G. A.
Carruthers, N. S.
Cook, Frank
Daw, Hubert
Glendining, V.
Hind, J. R.
James, H. L.
Levinson, W. E.
Lloyd, F. G.
*McNair, A. J.
Messenger, H. L.
Yerbury, E. O.
Mutch, N.
Sandison, A.
Slesinger, E. G., O.B.E.
Stephens, H. F.
Steinbach, H.
1912 Bennett, T. I.
Eccles, G. D., M.C.
Genge-Andrews, G. E., O.B.E.
George, W. S.
Hoby, H. J.
Keith, T. S.
Mayer, J. W.
Munden, M. M.
Passey, R. D.
Reynell, W. R.
*Smith, P., M.C.
Watkin, P. J.
Zamora, A. M.
1913 Evans, H. W.
Gwyn-Davies, W. L.
*Hancock, A. C., M.C.
Hopson, M. F.
Leigh, H. V.
Morgan, O. G.
Ryle, J. A.
Saul, E. R.
Tanner, W. E.
Thomas, C. G.
1914 Boswell, P. R.
Bull, Bocquet
Harkness, A. H.
Horsley, L.
Messenger, H. L., M.C.
Simmins, A. G.
Stallman, J. F. H.
1915 Coffin, S.
Curle, Reginald
*Jones, J. P., M.C.
Kendall, N. E.
Lloyd, V. E., M.C.
Matson, R. C.
Marston, A. D.
Medlock, C. H.
Symonds, C. P.
1916 Braine, J. F. Carter
Eady, B.
Halden, R.
Jerwood, B. E.
Jones, J. G.
Le Clezio, E. H. L.
Wacher, H. Stewart
Wright, J. A. S.
1917 Apergis, H. D.
Bulleid, A.
Conybeare, J. J.
Grice, J. W. H.
Staley, R. C. W.
Woodruff, K. M.
1918 Aldred, A. B.
*Gill-Carey, C.
Grace, W. H.
James, J.
Lansdown, R. B. P.
Lloyd, E. T.
*Millett, H.
Millar, R.
Victory, F.
Worth, H. M.
1919 Bradnack, G. A. A.
Braithwaite, J. V. C.
Bishop, C. D.
Griffin, J. H.
Hay, W. G.
Ledlie, R. C.
Moffatt, C.
Wolff, Sidney
Trethowan, W. H.
Vandermin, H. T.
Zorab, A.
1907 Aubrey, H. P.
Barnett, E. P.
Carlill, H.
Henderson, H. J.
Jones, C. E. M.
Litchfield, P. C., M.C.
Munden, W. P. H.
Palmer, B. H.
Reynolds, R. J.
Saunders, S. McK.
Ticehurst, C. B.
Watson, J. N.
1908 Chapple, H.
Fuller, F. H.
Morton Palmer, A. S.
Price, P. S.
*Reynolds, L. L. C., D.S.O.
Tasker, D. B.
1909 Attwater, H. L.
Bromley, L.
Greenwood, A. A.
Lees, A. E.
Mills, C. H.

1920—1921

1920 Burn, J. H.	1921 Crisp, E. J.	Strawbaum, A. E.
Burrill-Holmes, L.	Elkington, G. W.	Turner, Terence
Doherty, W. D.	Gills, L.	Shaw, M. E.
White, S. V.	Hopson, M. G. S.	Watson, L. K.
	Nootт, G.	Worthington, C. L.

* Vice Chairmen. † Date of Qualification.

Also Viscount Goschen, Sir Cooper Perry, Canon J. B. Haldane, Major Oswald Magniac, F. P. Whitbread, Esq., and the Editor of the GUY'S GAZETTE.

Peptic Ulcer.

DEAR SIR,—I have read with very great interest Mr. Grant Massie's communication from America on the subject of Peptic Ulcer, which appeared in your issue of September 17th, 1921.

It is not, I think, a matter for surprise that the surgeons have come to rely less and less on the test-meal as a diagnostic aid, particularly when the recent improvements in radiographic technique in the United States are taken into account. Nevertheless, it should surely be regarded as an excessive "swing of the pendulum" if the test-meal were to be omitted altogether from gastrological enquiries because it is not often helpful to the surgeons. The surgeon's concern is for the most part with gross structural lesions rather than with disturbances of function. X-rays may give direct evidence of such lesions, while the test-meal merely demonstrates disturbed motor and secretory phenomena which may or may not be dependent on an organic lesion or may be produced by more than one kind of lesion. The test-meal, except in pyloric obstruction, is not, therefore, and never can be, a diagnostic test, but it does provide useful information as to the secretory and motor functions of the stomach and should, I believe, be employed as a gastric efficiency test, whenever possible, in the routine investigation of cases of dyspepsia. In the case of duodenal ulcer the fractional test not infrequently gives suggestive confirmation when X-ray reports are negative, and in what might be termed the "non-surgical dyspepsias," most helpful information is often provided. Naturally, however, a large proportion of all cases examined show no considerable departure from the average normal type.

Gorham's criticisms would seem to demand careful consideration. I have not yet seen his original pronouncements, but feel that some counter-criticism should be offered to Mr. Massie's summary of his contentions.

Gorham apparently argues that a sample of gastric contents removed by ordinary methods cannot be regarded as representative because the gastric bolus remains so long unmixed, and on the strength of this throws doubt on the value of test-meals as at present conducted. This argument may be true in the case of a solid, dry meal, but when a fluid oatmeal gruel is used and when it is remembered that after an ordinary meal the digestive processes demand upwards of 2,000 peristaltic waves there should theoretically, even with less active peristalsis, be a good chance of successful mixing of the stomach contents. Further in the fractional process care is or should be taken to secure specimens from the same level throughout, and the markings on the tube and the weighted end should help to secure such a constant level. Other points in favour of the reliability of the samples obtained during the fractional test are, firstly, the fact that almost identical curves, whether normal or abnormal, may be procured again and again from the same individual, and, secondly, the fact that certain definite types of curve occur in certain definite types of lesion. The curves of pyloric stenosis and the hypersecretory curve of active duodenal ulcer are obtained with considerable constancy in these conditions.

Finally, even if a sample is not a representative sample of the whole gastric content its acidity, particularly when compared with the acidity of preceding or succeeding samples withdrawn at the same level, is evidence and as such cannot be wholly disregarded.

It must also be recognised that much other information besides that relating to the acidity of specimens is provided by the fractional method, and, as my colleague, Dr. Bennett, recently said to me in a discussion of these criticisms, no information coming from the inside of the stomach can really be considered as valueless in the study of gastric disease.—I am, Sir, Yours sincerely,

J. A. RYLE.

The Warden's House,
Guy's Hospital.
October 12*th*, 1921.

DEAR SIR,—In your issue of September 17th Mr. Massie, describing some of his impressions of the Mayo Clinic, states that little attention is there paid to the results of gastric analysis, and speaking particularly of the fractional method he quotes

Gorham's work as evidence of the unreliability of the results obtained by this method. I had hoped that this statement might have drawn a reply from Dr. Ryle, for Gorham's paper (Arch. for Int. Med., April, 1921) is being freely quoted, and if his conclusions are correct most of the work now being done by the fractional method must indeed be valueless.

Gorham gave a test meal of shredded wheat biscuit and water, and 45 minutes later emptied the stomach by removing the contents in 10 c.c. samples in rapid succession; he appears to assume that if the stomach contents are a homogeneous mixture with the acid uniformly diffused throughout it each of these samples should give a similar figure for the free HCl and total acidity. In a series of 65 cases he found that this was not the case, but that the figure, say for total acidity, might vary in individual cases between 25 and over 100. Only three actual cases with details of their curves are given, and two of these do not seem to me to be striking illustrations of his contention; in the third he is dealing with a case of duodenal ulcer and the acid curve of the successive samples rises steadily and steeply from 25 to 100. This very steady rise is to my mind evidence against rather than for his conclusions, at any rate it is what I should have expected from a priori considerations. It takes some time to empty the stomach in 10 c.c. amounts, and 10 to 15 minutes will almost certainly elapse between the beginning and end of the proceeding; during this time, with active gastric secretion which must have been occurring in the case in question, HCl is being steadily poured out into a steadily decreasing volume of gastric contents, and it is difficult to see how a steady increase in the acid concentration is to be avoided.

On the other hand I admit the possibility that the position of the end of the tube may make considerable difference in some cases. Some months before Gorham's paper appeared I had made a few observations on this point in the course of some investigations carried out in conjunction with Dr. Charles Bolton; after giving an Ewald breakfast a portion of gastric contents was removed 45 minutes later with the end of the tube 17 inches from the teeth, the tube was then pushed on to the 21 inch mark and the rest of the contents withdrawn. In most cases the two samples gave similar figures both for the free and total acidity, and also for the total and mineral chlorides, and in those cases where there was a difference the second sample always gave a lower figure than the first. On the whole I was reasonably satisfied that no great error from this source was likely to occur in employing the fractional method. It would, however, be very interesting to hear whether Dr. Ryle has any information on this point.

The noticeable regularity of the curves obtained by the fractional method, the fact that one individual repeatedly gives the same type of curve and the confirmation afforded by the work of Dodds on the curve of the alveolar CO_2 all seem incompatible with Gorham's conclusions, but there can be no doubt that these conclusions are receiving a ready acceptance in some quarters.

The point at issue here is, of course, quite independent of the value of gastric analysis in clinical diagnosis—a much wider question on which at the moment I have no desire to enter a controversy.—Yours faithfully,

GORDON W. GOODHART.

24, Warwick Gardens,
Kensington, W. 14.
October 8th, 1921.

Infant Welfare Centres and the Milk Question.

DEAR SIR,—Public Health Workers generally will, I feel sure, thoroughly endorse Dr. Cameron's censure of the Ministry of Health for turning Centres intended for educational and supervision purposes into free milk depots and the specially qualified workers into "Relieving Officers."

So extensively has this milk distribution grown that it has been almost impossible for Health Visitors, in many districts, to cope with the first visits, far less get them paid when the mother most requires advice. Too often the dreaded "bottle" has been introduced, for reasons which could easily have been avoided, ere the Health Visitor was there to counsel.

When I read the comment in "Passim" I felt that the writer was viewing the subject from the sentimental side; he had not handled the situation, not lived through it as we have. Dr. Cameron, with true insight, has gone to the root of the matter. *The free distribution of milk*—almost unlimited in some districts—*has been one of the greatest deterrents to breast-feeding* with which the country has had to cope. The mothers are urged on every second placard to use "The best food for baby." "So simple, add water and serve!"

The Ministry, by its grants, has increased the sale of dried milks and patent foods. The manufacturers are legion, and they are not philanthropists; they have taken every advantage of the situation, many offering prizes at Centres for babies fed on their speciality. This is not the way to raise an A1 Empire though it may be the way to coin money.

Fortunately in one Metropolitan borough, the chemists raised a storm at the amount of "cost price" food sold, and this, in many cases, to women

who were not attending the Centres with their children. In one of the slummiest and poorest City districts where dairies supplied free cow's milk on the Committee's recommendation, the Medical Officer had to insist that the mothers remember to draw their ration each day and not allow it to accumulate. This practice gave one food for thought—were the cases really so necessitous as the figures supplied suggested? Did they appreciate the grant?

Dr. Cameron refers to German statistics; I can furnish information from Poland which further proves his point. In 1919 the chief of the Children's Hospital in Warsaw told us that owing to the shortage of cow's milk, bottles, and teats, breast feeding had been almost entirely adopted throughout the country, and he averred that children so fed withstood the ravages of war for a much longer time than the artificially fed children. To prove that Nature will sacrifice everything for the preservation of the race we saw starved mothers with healthy infants at their breasts. Dr. Truby King asked me to obtain specimens of milk from these mothers for analysis, this I did in one or two cases, the specimens going by courier to London. The difficulty in obtaining definite information necessary for such work, however, prevented sufficient material being collected, but I distinctly remember the report on one sample "almost normal," while the mother, mere skin and bone, had fed for weeks on flour and water cake, cabbage leaves and now and again potatoes. The importance of the Notification of Births Extension Act has been lost sight of by many Welfare Committees.—I am, yours, etc.,

J. B. N. PATERSON.

DEAR MR. EDITOR,—Dr. Cameron in his letter quite ignores the fact that the success of the Anti-Waste League and not German statistics, was the cause for the reduction in the free-milk grant from 50 per cent. to 5 per cent. The very terms in which the Premier accepted Dr. Addison's resignation showed that the policy of the new Minister was not to be more scientific, but more "business-like," and in this case scientific and business-like are not synonymous. It would certainly be more scientific to have separate agencies for distributing doles of food, but as it would hardly be politically more business-like, with the Anti-Waste League performing so near Westminster, Dr. Cameron is not likely to see his suggestion adopted.

Had the Minister of Health shown that it was his genuine belief, that even under the present unprecedented conditions of unemployment, when so many mothers are bound to be underfed and undernourished themselves, infants would thrive better when breast-fed, one could not have objected to his cutting down the milk grant, but coming as it did, so soon after the Anti-Waste cry had been started, and in between the Westminster and Lewisham elections, his attitude was surely shown up in its right perspective, by the *Star's* Cartoon.

MILK FOR BABIES.

A Buried Dental Swab.

DEAR SIR,—I have only to-day heard a tale of mystery, which will interest the dental as well as the general student.

A hitherto healthy young male adult in a City office was noticed by his employers to be ill. He gradually got thinner and more exhausted. His urine contained sugar, so he was labelled as a "diabetic." One day, after he had collapsed at his work, the doctor noticed a mandibular swelling, corresponding to a stopped tooth. The tooth was extracted, pus was discovered, and *mirabile dictu* a buried pledget of wool. On removal of this wicked dental swab, hope revived, while the diabetic label was found to be untrue. The lad is now hearty and well, putting on flesh and doing full duty at his office—there his employer pointed him out to me to-day as an interesting curiosity.

Twice during the war I had to give an anæsthetic for the removal of a buried abdominal swab, but I have never before heard of such severe symptoms due to a neglected dental swab.

A. WITHERS GREENE.

September 29th, 1921.

Rugby Football.

DEAR SIR,—In a previous issue of the GAZETTE it was stated in "Passim," that rope seats had been arranged to accommodate spectators at Honor Oak Park. Had the United Services match been played on Saturday last, many would have been surprised to see that in spite of your statement in "Passim" there were no rope seats.

The fault is possibly mine for not making it clear, in my letter published in the same issue of the GAZETTE, that estimates for these seats had been obtained, and that, should the present seating accommodation prove to be inadequate, then the seats in question will be arranged on the ground.

F. W. Reitz's ability to play in any position on the field was mentioned in the last GAZETTE, but the writer doubted whether he had played half back. This he did on one occasion (in a match against the South African Army XV.) when, owing to an injury to F. Bekker, the scrum was worked by Reitz.—Yours truly,

S. P. MEACOCK.

Dental Society.

The attention of members is drawn to the fact that the first meeting of the Society will be held on Thursday, October 20th, at 5.0 p.m., in the College Smoking Room (Tea at 4.30).

"The Presidental Address" will be read by F. J. Pearce, Esq., followed by a few "Casual Communications."

It is hoped that there will be a good attendance both at this and all subsequent meetings.

The Secretary would be pleased to have the name of any member who has any Casual Communication to make.

Pass List.

L.D.S.

SEPTEMBER, 1921.

Mechanical Dentistry.

R. C. Ballard.
C. F. Shardlow.
P. S. Clarence.
V. R. Estment.
G. B. Longhurst.
M. Patlansky.
E. Samuels.
L. Weinberg.
W. O. Cooksey.
R. A. Tran.
J. G. Coutts.
S. G. French.
M. W. Meskin.
E. V. Potts.
R. Schlimmer.
H. J. Van Heerden.
A. H. Dyke.
J. B. F. Tunstall.
A. S. V. Daniels.
J. P. Hartman.
H. Metheringham.
B. Rubinstein.
L. P. Tupling.
M. C. Hart.
T. O. Clancy.
R. Edwards.
W. V. A. Hodges.
L. Nurick.
F. A. Sampson.
T. Vallange.
J. Luke.
L. M. Cartwright.
S. Eidinow.
L. S. J. Kanaar.
W. Orsmond.
C. P. C. Sargent.
C. A. Wakeford.

Dental Metallurgy.

R. C. Ballard.
W. O. Cooksey.
H. M. Doubleday.
A. H. Dyke.
C. H. Fox.
F. R. Taylor.
R. A. Tran.
J. B. F. Tunstall.
W. E. Berwick.
F. F. Brayfield.
R. C. Broadbridge.
J. S. Dick.
E. E. Gibson.
G. L. Gould.
W. E. Herbert.
A. Hirschberg.
W. F. Howe.
A. R. Jackson.
H. B. Kidner.
G. M. D. Mackie.
A. W. Reynolds.
J. F. Reynolds.
D. E. E. Robertson.
J. C. Rowbotham.
W. Rowland Hill.
J. E. B. Smith.
H. E. Spencer Payne.
W. H. Taylor.
L. C. Willis.
J. R. Palfrey.

Football.

ASSOCIATION.

Although players were troubled by the hard state of the ground, the practice matches held have been the means of finding some new talent. Two things that stood out were the unfitness of players generally and the reluctance of forwards to shoot unless within about four yards of the goal.

If three teams are to be run this season, we must have still more players. All members of the Clubs' Union are members of this club, but no student will be admitted unless a member of the Union.

GUY'S v. EMERITI.

The First XI. started their season on October 1st at Honor Oak Park. D. J. P. O'Meara and C. A. Wakeford were the chief absentees, the former will be out of the team for some time owing to his recent stay in the wards.

The hard ground made play both tricky and dangerous. Goals were scored by Morgan and Van Geuns before the interval; and in the second half by Nicolai (2) and Trott; the final score being Guy's 5, Emeriti 0.

This being the first match of the season the result was encouraging, though there is still great room for improvement. There was an utter lack of combination throughout the team, attack and defence not working together, with the result that advantages gained were not pushed home.

The forwards, especially the inside men, were too slow on the ball, and so many chances were lost. Nicolai, who was making his first appearance in the First XI., was slow in the opening half, but improved later, his two goals being excellent efforts. Why won't the inside forwards shoot from a longer distance? They don't appear content except when dribbling the ball to within ten yards of goal, with the result that they usually lose it.

The half backs were moderate with Couch the best of the three. Hewetson was not at all safe; while Painter, who worked hard, had the tendency to neglect the opposing outside left. He must try to mark his wing man more.

The backs, especially Riddolls, were safe and tackled excellently; while Hardy did all that was required of him.

Guy's Team.—E. Hardy, F. Collier, A. W. Riddolls, O. F. Painter, D. H. Couch, J. C. Hewetson, R. Van Geuns, F. Nicholai, L. S. Williams, L. A. S. Trott and V. R. Morgan.

Streptococcal Fever.

CLINICAL LECTURE BY DR. J. A. RYLE.

GENTLEMEN,—During the past year or two I have had occasion to see at the bedside or in the post-mortem room a number of cases in which, following some initial local infection, there has been a sudden general invasion of the tissues by streptococci. The subject of these general infections seemed to me to be worthy of review from the clinical standpoint.

As you are aware, streptococcal septicæmia is a very serious condition with a high mortality; it is also, though less common than formerly, by no means a rare event. It is encountered alike in the practice of the surgeon, the physician and the obstetrician, all of whom feel for it a very real dread. You will not, however, find in the ordinary text-books detailed pictures of the disease, for it has been the custom either to regard it briefly as a grave complication of some other illness or injury, or to group it with other blood-stream infections under the general heading of Septicæmia.

There are, nevertheless, certain clinical features which I believe to be characteristic at any rate of one common type of acute streptococcal fever—for we must remember that there are many varieties of streptococcus and several clinical types of infection—and it is of these features by which you may be helped to recognise the condition that I wish particularly to speak.

You must realise that the ultimate diagnosis of a streptococcal or any other septicæmia can only be made by the bacteriologist, but the bacteriologist is not always or everywhere available, and even if he were, that does not absolve us from the duty of trying to arrive at a strong clinical presumption of what, in a particular case of fever, the infecting organism is likely to be. In typhoid and cerebro-spinal fever for instance early clinical suspicion must always precede laboratory confirmation and so pave the way for active and appropriate treatment, and in some conditions, like diphtheria and cerebro-spinal fever, it may be inadvisable to await bacteriological confirmation before commencing specific treatment. We cannot, I think, be too mindful of the fact that, in acute illness especially, early and accurate diagnosis is the first essential of treatment, and that the primary responsibility is the the clinician's, even if his powers of decision are not absolute.

I do not propose to deal here with the pyæmic streptococcal infections presenting surgical problems with joint involvement and abscess formation, though these may follow acute streptococcal fever, nor to consider infective endocarditis which is so frequently due to a streptococcus and is also a septicæmic disease, nor yet those purely terminal infections of other grave illnesses, which are as a rule only recognised at the post-mortem examination. I hope that I shall make myself clear as to the definition of streptococcal fever as I go, and that I may perhaps succeed in reminding you of features which you have yourselves observed from time to time, for, whether it be in Patience or Samaritan, or in the medical wards, or the P.M. room, there must be sufficient cases in the course of the year for most of you to see examples of the condition during your time in the wards. I have recollections of eight or ten cases seen in various parts of the hospital during the past eighteen months or so, and my experience cannot be unique.

To obtain a clear clinical picture of any infection we must have an understanding of the portals of its entry. With regard to the streptococcus we are accustomed to think of a wound as the commonest site of invasion, and the surgeon's or pathologist's pricked finger followed by a fulminating and often fatal illness affords dramatic instances of this, but of course any wound may be infected with streptococci as those who have had experience of war-wounds know only too well. By the end of the war surgeons had learned how to combat with a certain amount of confidence the activities of the anærobic organisms, but the streptococcus was, and is still a baffling enemy. Incidentally it was in dealing with streptococcal wound-infections that I first became familiar with some of the special symptoms which characterise streptococcal fever, and which I shall try to describe to you.

After wounds the uterus, following the puerperium, is still one of the lamentably common sites of invasion. In the medical wards the tonsils, less commonly the teeth and occasionally the respiratory and intestinal tracts are the usual primary foci, while we must not forget the skin in erysipelas.

As regards the type of fever, it is possible in extremely rapid and virulent cases that there may be no recorded pyrexial reaction before death occurs, but in the majority of cases high fever, with spikes reaching 105° or 106° and a sustained but swinging curve, is customarily seen. In the more chronic forms of streptococcal fever the temperature curve may take on a regularly intermittent character. As in other blood-stream infections rigors are common.

Rigors in fact are probably the best clinical evidence we have that bacteria, parasites or at any rate foreign proteins of some kind have entered the general circulation. In malaria for instance it has long been known that the ague-fit is the clinical expression of a great multiplication of the malarial parasites in the general circulation. The initial shiver in pneumonia is a period of invasion at which organisms can be found in the blood-stream. In septic and thrombotic conditions such as sinus thrombosis, the rigor is a well-known warning sign of septicæmia. Following large intravenous injections shivers may occur, and it has been suggested that these are due to dead organisms. The course of the fever may be from a few days to many weeks.

So far there is nothing in the description I have outlined to suggest the type of infecting organism. There are, however, four manifestations which we may regard as very suggestive of streptococcal fever. They are firstly diarrhœa, often very frequent and troublesome; secondly the presence of albumen red cells and casts in the urine, and occasionally of still more patent evidences of nephritis, such as "smoky" hæmaturia and diminution in the output of urine; thirdly, rapidly progressive anæmia and emaciation; and fourthly, a curiously smooth, red, desquamated tongue.

I think it would be fair to say that any high, sustained fever, in which two or more of these manifestations—diarrhœa, nephritis, progressive anæmia, and a raw tongue—are present, should rouse a very strong suspicion of streptococcal septicæmia. These features I am inclined to regard as especially suggestive of infection with streptococcus hæmolyticus.

The presence of nephritis and diarrhœa together is not a very common one in other acute conditions, and there is no other fever in my experience which produces so steadily an increasing pallor from day to day.

As to the significance of the nephritis and diarrhœa, one can only presume that both the bowel and the kidneys in their attempt to excrete streptococcal toxins, which appear to have a strong cyto-lytic action, themselves become irritated and inflamed. I think it is more correct to regard the entero-colitis and nephritis as being due to toxic products rather than to local infection with the organisms themselves; I have, for instance, seen a case of streptococcal fever due to a local peritoneal infection with persistent diarrhœa and progressive pallor, in which blood-culture was negative and improvement rapidly followad local surgical measures. Whether the causal organisms are recoverable from the urine or fæces in these cases I do not know. The anæmia is probably an index of the activity of the streptococcal hæmolysins, though I cannot state for certain whether this and the other symptoms are clear evidence of infection with streptococcus hæmolyticus. In the war wounds streptococcus hæmolyticus was commonly isolated, and these special symptoms were frequently noted in the graver cases. Other clinical features which should of course be looked for are splenic enlargement or tenderness (the spleen is softer and has a less definite edge than in infective endocarditis or typhoid fever), purpuric rash, and evidences of inflammation of serous membranes, particularly the pleura and pericardium. Scarlatiniform rashes followed by desquamation, and blotchy erythematous rashes are also seen. The pulse is always rapid, usually

120 and upwards, and of poor quality, and there is generally a leucocytosis of from 12—30,000. As to the confirmation of the diagnosis, blood-culture taken at the time of an evening pyrexial "spike" or in the neighbourhood of a rigor is the obvious method, cultivations from local foci giving merely presumptive evidence; a single negative culture should not be taken as excluding a blood-stream infection.

I should like to digress for a moment on the subject of blood-cultivations. To my mind they should, when circumstances permit, be performed much more systematically in all cases of obscure pyrexia with figures ranging above 101°—102° than is the rule, and they should be performed at the earliest possible phase of the disease. Apart from helping us to secure earlier and more accurate diagnoses in the grave infections, it is quite conceivable that the method would in time reveal to us the nature of some of the more transient undiagnosed fevers, and although we must expect to draw a high percentage of "blanks" that does not absolve us from employing a technique which is at once simple and harmless to the patient.

The blood should be taken preferably in the evening, when the temperature is highest and at a point as near as possible to a pyrexial spike or a rigor; it should be drawn from the median basilic or any other convenient vein, with a syringe preferably dry-sterilized, and the hands should be dry. Four to eight ccs. are withdrawn and the amount divided among several test-tubes of the culture medium.

It may be of interest to you to hear a brief account of cases representative of this type of infection. So far as I can recollect the first cases in my own experience during the war in which I especially noted the association of diarrhœa and pallor with streptococcal septicæmia were chest wounds with infected hæmothorax from which a hæmolytic streptococcus had been cultivated, and which generally ended fatally. Then there came under my care a case of lobar pneumonia with all the classical physical signs of massive consolidation, but a chart which was not typically a "pneumococcal" chart. The man developed diarrhœa and became very pale, and I made a provisional diagnosis of streptococcal pneumonia. The juice obtained by lung-pucture and blood from the median basilic vein both gave a pure growth of a streptococcus.

Among the cases which I have seen more recently four or five were cases of puerperal sepsis, one of septicæmia following tonsillitis, and one of sudden collapse and death following a few days of sore throat and diarrhœa, in which there was no apparent cause of death demonstrable at autopsy, but a markedly hæmolytic streptococcus was grown from the heart's blood. One case started with acute diarrhœa and vomiting, and abdominal pain, and later localized in the peritoneum, and another was probably a throat invasion, though there was no complaint of sore throat.

It is worth remembering that streptococcal septicæmia is an occasional cause of sudden unexplained deaths, such as occur in the fulminating forms of cerebro-spinal fever. In such cases the throat is the probable portal of entry.

One is tempted to regard the nephritis which follows tonsillitis and scarlet fever as an index of the frequency with which there is a streptococcal throat invasion in these cases, although the other features of streptococcal fever are not necessarily present, and, indeed, recent work suggests that scarlatina has a streptococcus of its own; it is not improbable also that streptococcal toxins were responsible for the nephritis which sometimes accompanied the influenzo-streptococcal pulmonary infections in the recent epidemics.

If you seek further evidence for the frequency of diarrhœa as a symptom of streptococcal infections you have only to turn to the old accounts of the terrible epidemics of puerperal fever, the worst forms of which are now generally regarded as being due to streptococcus hæmolyticus. Diarrhœa is here recorded as a very constant and often an early symptom, it is not necessarily an accompaniment of a late pyæmic stage, nor do I think it is adequately accounted for by saying that it is due to local peritoneal irritation.

Trousseau in his lectures gives a beautiful clinical account of puerperal fever, followed by a clear pathological discussion which needs little revision even now; he makes mention of diarrhœa as an early symptom, and also of the contrast often noted between the patient's alert mental condition and her desperate physical plight, a very remarkable feature of these cases.

Reference to the clinical and post-mortem reports of this hospital will also give you an indication of the prominence of diarrhœa as a symptom of puerperal septicæmia, and the nurses in Patience will tell you how troublesome a feature the diarrhœa may be.

In a case of puerperal sepsis which I saw recently diarrhœa, nephritis and profound pallor were the three outstanding manifestations; incidentally the baby died of umbilical sepsis and streptococci were isolated at the autopsy, where the characteristic staining of the endocardium and the aortic intima were clearly shown.

You may very naturally ask whether these manifestations on which I have laid particular stress are not also met with in other types of septicæmia. Neither from my own experience, nor from references to the text-book descriptions and the clinical and autopsy reports have I been able to convince myself that diarrhœa, nephritis, rapidly increasing pallor, and the raw-looking tongue are so characteristic of the other common bacterial infections. Entero-colitis and nephritis may both occur in the course of pneumococcal septicæmia, and pneumococcal septicæmia is the one which may most closely simulate clinically a streptococcal infection. In this connection, however, we must remember that there is a relationship so close between the pneumococci and certain of the streptococci that they are not always easily distinguished even in the laboratory. I have found records of several cases in the post-mortem reports of recent years bacterially diagnosed in life or at autopsy as pneumococcal septicæmia in which colitis and nephritis, occurring severally or together, are mentioned, but taking into account the very large number of pneumonia cases and of other pneumococcal infections which pass through the hospital these complications would seem to occur in a small percentage of the whole.

Let us consider briefly from the point of view of differential diagnosis the characters of the common septicæmic diseases.

The usual features of a pneumococcal septicæmia, apart from the high, sustained fever, are:—the absence of any obvious primary focus, unless the lung be regarded as such; the hot dry skin, the tendency to localizing symptoms in lung, pleura, pericardium, meninges, peritoneum or joints, often without any actual localization; in children frequently splenic enlargement; and, in my experience, almost invariably a very definitely raised respiration-rate whether or not pneumonic signs are present. The general appearance of the case nearly always suggests pneumonia and the attention is generally focussed especially on the lungs.

In meningo-coccic infections, apart from the fulminating type with purpura, unconsciousness and rapid death, there are as a rule symptoms pointing to meningeal involvement, such as stupor, head-ache, Kenig's sign, and neck rigidity. In staphylo-coccal septicæmia there is the tendency to development of pericarditis and local and metastatic abscess formation, so often demonstrated in cases of acute osteomyelitis.

In typhoid there is diarrhœa frequently, it is true, but nephritis is rare; apart from secondary infections there is not a rapidly progressive anæmia, and the tumid abdomen, slow initial pulse, rose-spots and dazed mentality in the severe cases, together with leucopenia, and the absence of most symptoms excepting fever and malaise in the mild cases help to constitute a distinctive picture. Rheumatic fever must not be allowed to pass without mention, for there may be a severe multiple, non-suppurative arthritis in streptococcal general infections, though other features will usually help to distinguish the two diseases.

We find, in fact, that each fever has a characteristic syndrome of its own, though each shows wide variations and all have points in common. It is those in which fever alone is the outstand-

ing feature which are the most difficult to diagnose. It is those in which metastatic or localized infections are established, which are the most easy to recognise, but in which recognition is sometimes too late to be of much avail.

You will say that a streptococcal fever ought not easily to be missed because there must necessarily be a primary infective focus, and indeed excepting perhaps in the tonsillar or dental cases, there is not much difficulty in recognising the focus, and that the fever is a septic one, though sufficient care is not always taken to determine the organism or to decide whether and when the blood-stream is invaded.

Since I have stressed the importance of early diagnosis from the therapeutic point of view I must endeavour to make some suggestions as to the treatment in streptococcal fever. I think the most hopeful lines, looking forward, are those along which the serological treatment of pneumococcal and meningococcal infections has progressed. In these diseases the best results of late have been obtained, not merely by isolation of the organism and haphazard injection of stock serum, but by the determination of the type or group of the organism and continued intravenous or intrathecal injections of serum appropriate for the particular type, polyvalent serum only being used in the initial interval during which the type of the organism is being established by cultivation and agglutination tests. Four such groups in each case are described for the pneumococcus and the meningococcus. So far the streptococci have presented too big a problem and such specific therapy is not possible. Even so I think it is worth trying early and frequent administration of polyvalent serum in large doses of 30—60 c.c., preferably by the intravenous route and diluted with normal saline. In other acute diseases we have learned, generally speaking, to give large doses, and in urgent cases to prefer the intravenous route to any other. Always, of course, the primary focus must be dealt with as far as possible, in order to limit the absorption of new batches of organisms, and general principles must be followed in the treatment of special symptoms. Transfusion from an immunized donor in a case which survives long enough for the immunization to be performed, is a suggested method of specific therapy, but if the patient lives long enough for this, the prospects of natural recovery will already have greatly improved.

A careful watch must be kept for metastatic infections, which can be surgically treated. The administration of plenty of fluids, of alkalies and glucose to counteract acidosis, and constant attention to those thousand and one little points of nursing which help to secure rest and freedom from pain, and to encourage sleep—all these play a part of which the importance cannot be overstressed.

The post-mortem findings in a case of acute streptococcal fever which has not proceeded to the stage of pyæmia with metastases (and pyæmia is relatively rare in streptococcal as compared with staphylococcal infections) may be few and inconspicuous. Sub-pleural and sub-epicardial hæmorrhages may be seen or early pleurisy, but there are usually characteristic changes dependent on the hæmolytic action of the streptococcal toxins. The aortic intima and valves and the endocardium may be found deeply stained and of a velvety pink or deeper plum-colour. The spleen is large and diffluent, and on section moist-looking and of a deep pink or maroon colour.

In conclusion, I should like to quote to you, with the kind consent of Dr. Hurst and of Mr. Coburn, who was his clinical at the time, the notes of a case of streptococcal fever, which as registrar I had the opportunity to observe.

Charlotte I., aged 23, and married, was admitted for pain in the right buttock and diarrhœa on 26th February, 1920. Five weeks previously she had had an attack of tonsillitis and influenza. Three weeks later she had a double quinzy, which was opened. On February 22nd she developed uncontrollable diarrhœa and vomiting. The next day symptoms persisted and she also had sharp pain in the right buttock and pain on moving the right leg.

On admission her temperature was 104°, pulse 122, respiration 20. Cheeks flushed,

tonsils large and red, lower pole of spleen just palpable, urine contained albumen, red cells, leucocytes and granular casts. The pain seemed to be referred to the right sacro-iliac joint. Leucocyte count 12,000 on February 27th.

Cultivations from the urine were negative, from the fæces B. coli and streptococcus longus were grown; from the throat micrococcus catarrhalis, staphylococci and streptococcus longus. On March 7th blood cultivations grew streptococcus longus. Between March 12th and 18th, 120 c.c. of anti-streptococcal serum were given intravenously, and two rigors were recorded. On March 26th, although the temperature at the time was 104°, blood cultivations were negative. On March 31st, albumen having disappeared from the urine some days previously, patient suddenly developed œdema of both legs. The œdema soon disappeared. The temperature gradually fell, and the patient was discharged well on May 9th.

On two isolated occasions only did the respiration rate rise above 30 per minute. There was never sufficient indication for surgical interference in respect of the right sacro-iliac joint. I am indebted to Mr. Coburn for the very good notes on the case.

The serum did not produce any striking effect on the pyrexial curve, and it is impossible to say whether it had any influence on the course of the disease; its administration was started rather late in the disease, as the infecting organism was not at first recognised. It is just conceivable that some serum may have an anti-hæmolytic action without being anti-bacterial.

The case helps to show that in spite of its great gravity and the recovery of organisms from the blood, the disease has not necessarily a hopeless prognosis.

The prognosis is always difficult and always grave, but there is, especially in young people, a definite proportion of recoveries. If the patient survives the first week or fortnight his chances of recovery improve. A high leucocytosis of 20 to 30 thousand suggests a good reaction, and as in pneumonia, probably justifies greater hopefulness.

I have employed the term Streptococcal Fever partly in order to foster the analogy of a specific bacterial disease, and partly to avoid a certain ambiguity which attaches to the word Septicæmia.

Do we in using it distinguish sufficiently between a condition of bacteriæmia, in which organisms are finding their way into the blood and may be occasionally or momentarily demonstrable there, and one in which they are actually thriving and multiplying in the blood-stream? Further, can we exclude as non-septicæmic cases which have all the clinical characters of septicæmia, but which give repeatedly negative cultural results? On the analogy of typhoid fever and infective endocarditis we cannot do so, for in these diseases there is always a considerable percentage of cases in which blood-cultivations remain sterile.

You will find, I think, that the acute streptococcal infections will very much repay study. They are among the tragedies of medical practice, and our knowledge of how to deal with them is at present scanty. Here I have only given you in outline some clinical impressions based on a small series of cases.

In respect of all the blood-stream infections it is most essential to endeavour to correlate bed-side and laboratory findings, and to establish improved methods of prevention and early diagnosis, and active treatment. The problem is largely one for the pathologists, but without close observation, good records and ready assistance on the part of the clinicians, little progress can be made.

THE EDITOR will, at all times, be glad to consider articles or sketches, provided that they are accompanied by the writer's name and address, not necessarily for publication. The payment that the GAZETTE *can offer is merely nominal. Authors who desire reprints of their papers should make their own arrangements with the printers when they return their proofs. All contributions to be addressed to the Editor, "Guy's Hospital Gazette," Guy's Hospital, London, S.E.*

Reviews.

Medical Electricity for Students. By Miss A. R. I. Browne. (Oxford Medical Publications.) Price 12s. 6d.

There has been a long-felt want among teachers of Medical Electricity for some reference book to recommend to students preparing for examination in this subject. This want has now been filled by Miss A. R. I. Browne's book, "Medical Electricity for Students."

The subject matter is very simply and clearly stated, and covers the syllabus laid down by the Chartered Society of Massage and Medical Gymnastics.

The chapter on the Elementary Principles of Chemistry is very brief, but details principal points, and should be helpful to those students who have no previous knowledge of this subject.

Cricket.

RESULT OF FIRST XI. MATCHES DURING THE PAST SEASON.

Date.	Opponents.		For.	Agst.	Rslt.
May 7	Beckenham ...	A	172 for 7	187 for 8 (dec)	D
„ 11	Streatham ...	H	143	78	W
„ 14	Sevenoaks ...	H	112	258	L
„ 16	Private Banks ...	A	198	106	W
„ 18	R.A.F. Uxbridge	A	182 for 6	108 for 9	D
„ 21	Honor Oak ...	H	190	118	W
„ 24	U.C.H. (Cup Tie)	A	174 and 84 for 4	70 and 187 for 5	W
„ 25	Hampstead ...	A	222	139 for 6	D
„ 28	Bromley	A	125	190 for 5	L
June 1	Catford Wanderers	H	120 for 6	216 for 9 (dec)	D
June 4	L.C.W. & P. Bank	A	134	146 for 7	L
„ 8	Streatham ...	A	161 for 8	154	W
„ 11	Cyphers	H	221	118	W
„ 14	St. Bart.'s (Cup Tie) ...	H	326 for 5 (dec)	192	W
„ 18	Old Charlton ...	A	160 for 6	128	W
„ 22	Bickley Park ...	A	185	205	L
„ 25	Beddington ...	A	139	168 for 3	L
„ 29	Catford Wanderers	H	181 for 9	265 for 7	D
„ 30	St. Mary's ... (Semi-Final Cup Tie)		240 for 6	78	W
July 2	C.U.A.C.O. ...	H	168 for 5	230	D
„ 6	Gravesend ...	H	237 for 3	226 for 4	D
„ 9	Three Counties Asylum	A	234 for 5	246 for 3	D
„ 14	St. Thomas (Final Cup Tie)		223 and 112	271 and 110	L
„ 16	Honor Oak ...	A	77	277	L
„ 18	Cyphers	A	125	334	L
„ 23	Bickley Park ...	H	184	156	W
July 26	Thespids	H	235	76	W
„ 28	Past	H	218 for 5	91	W
„ 29	Bickley Park ...	H	80	291	L
„ 30	Bexley Mental ...	A	154	192	L
Aug. 6	Cane Hill Mental	A	274	131	W

BATTING.

	Innings.	Times Not Out.	Highest Score.	Runs.	Avge.
T. Wooldridge	32	6	103*	1046	40·2
S. Rose ...	15	1	95	445	31·7
L. B. Helder	30	4	61*	657	25·2
G. L. Shearar	30	5	79	591	23·6
G. D. Shaw	25	2	77	535	23·2
G. M. Stuart	10	2	44*	155	19·3
L. C. Willis	23	0	80	431	18·7
A. G. Ensor	23	2	50	352	16·7
J. Van Schalkwijk	19	4	42	250	16·6
R. C. May ...	8	4	16*	49	12·2
L. S. Williams	7	0	25	81	11·5
F. J. Biddle	18	4	52*	144	10·2
C. G. Curle ...	14	3	22	109	9·9
R. F. H. Duncan	9	0	22	63	7·0
H. B. Cahill	9	1	11	38	4·7

*Not out.

The following also batted in two or more matches:—A. Hirschberg (4·5), R. G. Pengelly (6·0), P. Harvey (8.5), H. A. H. Harris (10·8), J. C. Hewetson (1·3).

BOWLING.

	Overs.	Maidens.	Runs.	Wkts.	Avge
T. Wooldridge	255	40	878	61	14·3
G. M. Stuart	86	11	371	21	17·6
J. Van Schalkwijk	330	43	1190	61	19·5
F. J. Biddle	205	26	875	43	20·3
G. D. Shaw	240	33	958	41	23·3

Medico-Neurological Clinic.

WINTER SESSION, 1921—22.

I. *Clinical Demonstrations.*—Tuesdays, 12 noon—In Clinical Theatre (Surgical Block). Dr. Hurst, Dr. Hunt and Dr. Marshall.

Fridays, 12 noon—In the Anatomical Theatre. On alternate weeks. Medico-Surgical, or Medico-Special Demonstration, by Dr. Hurst with Mr. Rowlands, Mr. Bromley and the Specialists; and Neurological Demonstration by Dr. Symonds.

II. *Consultations in Addison and Mary* (for qualified men only).—Tuesdays, 10.30—12—Neurological. Dr. Hurst and Dr. Symonds.

Fridays, 10.30—12.—Medical. Dr. Hurst and Dr. Hunt.

Birth.

WICKENDEN.—On October 9th, 1921, at Marshall Place, Perth, N.B., the wife of Stanley Wickenden, M.R.C.S.Eng., a son.

Ed.—A. T. R.

GUY'S HOSPITAL GAZETTE.

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Passim.

ON another page will be found a notice which sets forth the latest scheme for running the Front Surgery. This has been in operation for a fortnight now and is working fairly well though several disadvantages have become apparent. The chief grievance (beyond the fact that it robs medical ward clerks of their best excuse for missing their physicians' rounds) is that the dressers who are actually taking-in are supposed to be on duty at the Surgery from seven o'clock in the evening until nine-thirty next morning. A take-in dresser's life is never an easy one, and it is in the four hours from seven to eleven at night that he is usually hardest worked. This is the time of the day when most of the emergency operations are done, which it is imperative the take-in dresser should attend. If he cannot leave the Surgery much of his take-in week (for nowadays owing to the superfluity of dressers he only takes-in once in his three months) is lost.

Except for this the scheme seems to be quite a good one. It certainly does not send the first three months' medical ward clerk down to the Surgery to doctor Borough mothers who know far more about medicine than he does, and it so takes a load off the harassed shoulders of the Out-Patient Officer. Whether it will work as well in the coming three months, when, we are told, there will not be more than four dressers to each full surgeon's firm, remains to be seen.

ON Saturday last Guy's played their first home Rugby match of the season; and we were able for the first time to learn from our own experience all that had been done to improve the ground from the spectators' point of view. Firstly, the stand has been altered and enlarged. It is also far more accessible than it used to be. One does not have to stumble over the toes of earlier comers right along the long rows of seats (or what is more comforting one does not have late comers stumbling over ones own toes) for there are now ample gangways provided. Two tiers of duck-boards have been laid round the field, but no rope seats have yet appeared. The Hon. Secretary, we understand, has these seats somewhere up his sleeve and will produce them if there is still a demand for seats more than sufficient to fill the grandstand. While on this subject we would urge all men who wish to obtain seats in the stand to take advantage of the sale of tickets on Wednesdays and Fridays at the Hospital. Last week comparatively few men bought their tickets on these days, and there was in conse-

quence an unnecessarily large crowd applying for seats on the day of the match. If men will only buy tickets at the Hospital much time will be saved.

WE see that the Gloucester newspapers have revised and republished the unnecessary and unsportsmanlike tirade against the Guy's XV. which they perpetrated last year. We are sorry that we proved such an easy meal for the Gloucester giants, and we hope that it was not out of any feeling of compassion for us that they forbore to score in the second half of the game. Nevertheless, it is quite time that they learnt in Gloucester how to take their successes like men.

WE offer our congratulations to the Water Polo Team on their winning the University of London Cup. An account of the final match against University College will be found on another page. We now possess both the Inter-Hospital and University Water Polo Cups, and we carried off most of the trophies offered for inter-hospital competition in Swimming, so that the Swimming and Water Polo Club is able to look back upon an eminently successful season.

IT is unnecessary for us to announce to anyone living within a quarter-mile radius of the College that the "Niggers" have begun practising.

MR. CONYBEARE, who has taken over the position of Secretary of the Clubs' Union in place of Mr. Lane Roberts, is anxious that the rights of members shall be protected. As it was pointed out in "Passim" a few weeks ago, there are still two or three hundred men whose subscription to the Union is in arrears, and we have no guarantee that they are playing the game and abstaining from using their privileges of membership. There are still men who read, dine, and even live in the College without having the right to do so. Mr. Conybeare suggests that on some unstated day a general "hold up" be held at midday in the College, when all men would be asked to show their membership cards. This would help to find out which men are preying on their fellows, and we would ask all members to assist this scheme by always carrying their membership cards and by producing them without demur if they are asked for.

ALL of us who are at the Hospital were grieved to hear so suddenly of the death last week of Dr. John Biggar, Jnr. Dr. Biggar has scarcely been with us a year, having come over from America (where he had practised medicine many years) to study at Guy's and to obtain an English qualification. In this short time, however, he had come to be known and to be liked by a great number of men here. Personally, we encountered him oftenest in the College Dining Room, where he was always willing to entertain us with a long series of anecdotes of life in America. He entered into all the Hospital activities with a vigour that one would hardly have expected from a man of his age, and enjoyed the Cup Ties and Christmas Celebrations as much as any care-free first year man. Everyone was sad when the news spread that he was suffering from a pharyngeal new growth and sadder still to learn of his death after operation.

ON page 432 our readers will find yet another contribution on the long-drawn-out discussion on the policy of the Government in financing (to a certain degree) the distribution of milk to nursing mothers. This is, how-

ever, more than a mere letter of destructive criticism. It is an ably-written commentary on the advantages and disadvantages of breast-feeding, and on the economic possibilities of this means of infant feeding in poor neighbourhoods. We think that, this letter being read, it will be agreed that the Health Ministry were wise when they decided to reconsider their decision to cut down so ruthlessly their grant to the Welfare Centres. For while we have been so long discussing this subject in our columns the Government have seen the error of their ways and (not before time) have withdrawn from us our bone of contention.

THE Honorary Secretaries of the Boat Club have asked us to draw attention to the approach of the date fixed for the dance which this Club is giving at the Wharncliffe Rooms.

The Boat Club is one of the youngest of our clubs, and one of the most progressive. Not satisfied with its prowess on the Thames, it is determined also to be in the forefront in the social side of the Hospital's life. Last year it was the only one of the Athletic Clubs to hold a dance of its own, this year it is the first. It is, therefore, almost the duty of the dancing men of the Hospital (even if they do not row) to be at the Wharncliffe Rooms on Thursday next.

THE Biennial Dinner has come and gone. It was so successful and so delightful that one feels sorry that one will have to wait two long years before the next dinner is held. Mr. Ormond deserves our best thanks for the many months of hard work which the dinner meant to him, but we think that he spoke very truly when he said in answer to the toast in his honour, "You have been a lot of trouble, but I think you're worth it."

A Lay Cure.

["Learn a sonnet of Shakespeare's when you are shaving in the morning" is Sir Charters J. Symond's recipe for mental fitness.]

How many moments in the day
Unprofitably glide away!
How many men recite an ode
While they are walking up the road?
How many women learn a ballad
While washing lettuce for the salad?
I, too, was once among the slack—
Sir Charters' words have brought me back,
And now, as these few lines will witness,
I tread the way to mental fitness.

Thus: in the morning, when I wake,
I start the day with "Break, break, break";
While for my bath I run the water
I've time to learn "The Miller's Daughter";
Then, lathering my hirsute chin,
I drink a Shakespeare sonnet in.
Together with my eggs and ham
I feast on "In Memoriam,"
And take my toast and marmalade
To Tennyson's "The Light Brigade";
Then, neatly rolling up my brolly,
Declaim "Hence, loathéd Melancholy,"
And, as I hasten from the house,
I carol Burns's "To a Mouse."
While to my morning strap I cling
I learn an "Idyll of the King,"
Or if, instead of trains, I bike it,
Repeat a scene from "As You Like It."

I never waste my brain a minute,
But keep on cramming culture in it,
And all my mental clouds disperse
By taking constant draughts of verse.

But when my wife is buying bonnets
I need more solid stuff than sonnets;
In fact, if you will credit me,
I saunter through "Aurora Leigh"
And half-way through "Evangeline"
While she compares the blue and green,
And by the time she's chosen yellow
I've reached the last lines of "Sordello."

B. N. S.

From *The Manchester Guardian*, 26th October, 1921.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

Welfare Centres and their Work.

DEAR MR. EDITOR,—

I have refrained from commenting upon the subject of Infant Welfare Centres and the purpose of their work because I felt sure that there are many who understand the reasons which have been responsible for the introduction of this scheme, and that your postbag would be a heavy one. As one who has had exceptional opportunities of observing the work of the London Welfare Centres during the past three years may I add a few paragraphs in an attempt to explain the apparent change of policy which was responsible for your original remarks in "Passim" of the 17th September last?

In the first place, Mr. Editor, you are yourself the cause of the vast correspondence which has covered the editorial desk. You considered that Mr. David Low's cartoon in the *Star* newspaper was "an excellent cartoon."

I regard it, apart from its clever penwork, as a thoroughly bad one because it is typical of political propaganda of the present day. It has been published with a political motive to discredit the party in power and to put another party in office. The real reason for the curtailment of the Government grant to the Welfare Centres, from 50 per cent. to 5 per cent., is that for the moment the Nation's account is overdrawn, the Budget, 1921—1922, has failed, and every possible effort must be made to avoid further borrowing if the Sterling Exchange on Wall Street is to continue to rise—3·94 dollars at the time of writing—for upon the maintenance of that improvement the betterment of our trade and of the condition of our workpeople largely depend.

The Ministry of Health is well aware of the immense work which the Welfare Centres are doing and of the great success which already has followed their efforts, and the diminution in the Government grant is not the result of the loudness of the Anti-Waste cry as your correspondent who signs anonymously in your last number—15th October—would wish your readers to believe.

Secondly, there would seem to be in the minds of some people confusion as to the real reason for the institution of the Maternity and Infant Welfare schemes, for the mere fact that such provision is necessary is an admission that there has been a failure of Mothercraft in the home and that the State is making an attempt to remedy the defects. What is the reason that Welfare Centres are required?

It is that there is a correlation between a high percentage of unemployment and an excessive incidence of infant mortality. That is the real reason that workers are wanted who although they may be specially qualified for their posts are also endowed with that largeness of heart which will enable them at the same time to undertake duties which some might regard as more fitted for relieving officers. Welfare Centres are centres first of all for the relief of those who are unable by lack of knowledge, and too often by lack of money, to provide adequately both in matters of dietary and environment for their babies. Abuse there will be always, but there has been little compared with the immense benefit that has resulted and the enormous amount of infant life that has been saved. I see nothing more unusual in one woman endeavouring to obtain a packet of dried milk for herself or for her baby without payment owing to an incompetent and neglectful distributor, than in another woman travelling in a first class carriage with a third class ticket from Victoria to High Street Kensington without detection by a ticket inspector at Sloane Square. Both errors may be prevented.

Nor is it a matter of viewing the subject from the sentimental side as is imputed to you, Mr. Editor. The maudlin sentimentality of the present day is shown in the allotment of a whole page in the *Times* newspaper to applications for money to relieve famine in Russia while nursing mothers are starving in Queen's Buildings, in St. Margaret's Court and in Barbel Street. We too have handled the situation and lived through it, Mr. Editor, and we can tell you where distribution of milk has not been wasted and where it has been wanted and not provided.

Thirdly, I want to say a word on the subject of Breastfeeding. There are some who consider that it is both possible and advisable to continue the breast-feeding of the infant under all conditions of industrial life. Dr. Truby King is an enthusiast on this subject. Many of us have heard him lecture and have admired the work which he started in New Zealand. You cannot, however, compare the industrial conditions which prevail in the City of Christchurch, New Zealand with such as are prevalent constantly in the Riverside districts of South London and more especially at the present time owing to general unemployment. May I give you one example of such local conditions as affect us especially in South-East London. About two miles east of Guy's, between Rotherhithe and Deptford, lie the Surrey Commercial Docks. A vast population obtain a livelihood by work which is there provided, for we sometimes forget that "London River" as the seamen call it is one of the largest seaports of the world. Labour is of necessity casual, being dependent upon climatic conditions, fog or gale at

the Nore as well as tidal conditions in the fairway which delay shipping, but in addition for three months in every year there is absolute unemployment for an enormous number of men, and this unemployment is not dependent upon the chance that a Coalition Party is in power, or that a Labour Government has replaced it, nor upon the possibility that Dr. Addison or Sir A. Mond may be for the moment Minister of Health, it depends upon the fact that once every year the Baltic freezes and no timber arrives at these docks during January, February and March from that sea. As a result—at once and immediately you are face to face with the problem of married women's labour which, because of the necessity that prompts the applicant, is the cheapest labour of all. Here are some details from my out patient notebook on home conditions collected before the war between the years 1905 and 1914. I do not find that at the present day the wage—though it is higher—has increased to any marked degree in its "buying value" for the necessities of the home:—

1. Mrs. F.—"Mantle making," machine work collected by the worker from a Southwark depôt for a City firm. Ten or twelve mantles or coats are finished weekly and ten or twelve shillings is earned.

2. Mrs. C.—Jar and bottle washing. Jam factory. Wages 10s. weekly. Hours 8.0 a.m. to 7.0 p.m. Dinner hour 1 to 2 p.m., and tea 4 to 4.30 p.m. Work especially in January, February and March before the summer jam season.

3. Mrs. E. B.—Laundry hand. 10s. weekly.

4. Mrs. C. G.—Collar stitching—linen. Three button holes. For 12 collars, 2¼d. paid.

5. Mrs. B.—Mantle making, machine work in a workroom. 4½d. per mantle paid and worker "finds own cotton." Poor materials for third rate goods. Can earn 8s. weekly.

6. Mrs. M.—Laundry hand, ironer. Week-days 9.0 a.m. to 9.0 p.m., less 1½ hours for meals. Saturdays 9.0 a.m. to 4.0 p.m., less ½ hour. Average 60 hours per week. Wages 14s. weekly.

7. Mrs. A. D.—Waitress tea shop. Wages 10s. 6d. weekly. Teas provided free, and 1s. 6d. weekly deducted for dinners, if provided.

8. Mrs. A.—Office cleaning in the City. Hours 7 to 9.0 a.m. and 6 to 8.0 p.m. Wages 12s., less travelling expenses.

The above are typical of "married women's labour"—and I could quote many more. The point that I wish to emphasise is that it is for this type of family especially, and for this type of locality that the Welfare Centre Scheme has been started. Moreover, after 16 years of out-patient work I will not even admit that in the long run for such a mother and such an infant that breast-feeding pays, unless supplemented by provision of dry or fresh milk for mother or child; and with the knowledge of such home conditions I should feed the child with undiluted citrate milk or a dried milk of good quality without sugar excess.

The mere fact that an apparently healthy child can be found at the breast of a half-starved mother is no argument for breast-feeding in such a case. The important point is to know if that child will develope into a 32-inch baby, with straight legs, weighing 28 pounds at two years of age, and still more important to know that the mother for whom there are the possibilities of other pregnancies and other healthy children has not died as the result of her malnutrition or from such a complaint as osteomalacia.

Furthermore, my case papers do not show that the provision of milk, fresh or dried, free or at cost price, has acted as a deterrent to breast-feeding as is suggested by one of your correspondents. Thus, during an investigation dealing with the relative importance of environment and diet in the causation of rickets, out of 428 control cases of healthy children who have been under observation during the past three years, there were 186 healthy controls who were born in rachitic families which included 533 cases of rickets and 8 cases of delayed ossification, already under observation. The table below shows how all these 186 healthy children were fed. It will be noticed that the Welfares have succeeded in supplementing breast feeds where necessary and in preventing the onset of rickets and other forms of malnutrition in an increasing family with a diminishing income per head:—

186 control cases born in families with rickets cases already under observation. These control cases were fed thus to the age of 12 months:—

	cases.
1. Breast-feeding alone—no other milk used	47
2. Breast-feeding for short periods then fresh milk	77
3. Breast-feeding for short periods then dry milk	24
4. Fresh milk—no other form of milk used...	7
5. Sweetened condensed milk then fresh milk	3
6. Diluted fresh milk then sweetened condensed milk and a "war diet" from 12 mos.	1*
*V.H., a healthy child, but small height and weight for age.	
7. Breast milk for short periods then sweetened condensed milk with an adequate diet, including dripping and bacon fat	18
8. Allenbury, 1, 2 and 3, with fresh milk in sequence	2
9. Dried milk—practically nothing else ...	4
10. Dried milk then fresh milk	2
11. Fresh milk with Allenbury 2 and 3, then dried milk	1
Total	186

In other words breast-feeding was employed for ten to twelve months in only 25 per cent. of the total 186 cases, and of the 47 cases so fed, nearly half the mothers were receiving either dry or fresh milk at special rates during either the antenatal or lactation periods and in some cases for both.

The great majority of these Welfare Centres are in South London between Deptford and Lambeth. The example given of the docker's family is only one of many for whom there are annual periods of complete unemployment, quite apart from the present distress, which is due to exceptional circumstances and has involved almost all industries.

It is also well to remember that at such times lactation for prolonged periods is practised by some mothers for no other reason than to save money which would otherwise be required for the purchase of milk. I have known of this practice for years, it is not a post-war habit nor accidental to the present distress. All my three lady visitors confirm this statement.

It may also be of interest to record that out of 533 cases of rickets under observation in the last three years, in no less than 88 (*i.e.* 16·5 per cent.) signs of rickets appeared while the child was still at the breast and receiving no other form of milk food. Of these 51 were fed at the breast for more than twelve months, in one case up to the age of three years. In all these instances the prolonged lactation was for money saving reasons. In 37 cases the child did not thrive on breast milk, and the mother was ill or insufficiently fed.

The undermentioned tables show how the cases have been classified:—

1. *Breast-feeding*, prolonged. 51 cases. Rickets. In every instance lactation was prolonged in order to save money.
   - (a) Severe deformities 2
   - (b) Slight deformities 43
   - (c) Prerachitic—early signs only 6

Length of time fed at the breast.	(*a*) Severe.	(*b*) Slight.	(c) Prerachitic
For 24 months ...	1	6	—
For 22 months ...	—	1	—
For 20 months ...	—	2	—
For 19 months ...	—	1	—
For 18 months ...	—	9	—
For 17 months ...	—	4	—
For 16 months ...	1	4	2
For 15 months ...	—	9	3
For 14 months ...	—	5	1
For 13 months ...	—	2	—
Totals	2	43	6

Note.—In three of the above cases the mother was engaged in married women's labour.

2. *Breast-feeding.* "Poor breast milk." 37 cases Rickets.
   - (a) Severe deformities ... ... Nil
   - (b) Slight deformities 30
   - (c) Prerachitic—early signs ... 7

Condition of Mother.	*Length of Lactation.* 6 mos.	7 mos.	8 mos.	9 mos.	10 mos.	11 mos.	12 mos.
(1) Mother was ill. Anæmia. Nervous exhaustion. Infective disease.	1	—	1	2	2	—	2
(2) Mother in "poor" health Father unemployed.	1	—	—	—	1	1	7
(*c*) Mother ill-nourished. War-time lactation diet,	2	—	1	2	3	1	7
(*d*) Mother losing weight latterly. Cause unknown, Rickets attributed by mother to heavy weight of child.	—	—	—	—	—	—	1*
(*e*) Mother pregnant	—	1†	—	—	1‡	—	—

Note.—In *ten* of the above cases the mother was engaged in married women's labour.

*Prerachitic signs only. Complete recovery of child.

†For five months of the seven months' lactation the mother was pregnant with her second child. She was also at work. Signs of rickets appeared early, Prerachitic. Subsequent recovery with hand feeding.

‡For four months of the ten months' lactation the mother was pregnant. Prerachitic. Subsequent recovery with hand feeding.

As is well known it is the practice among tribes and races who live under more primitive conditions to employ breast-feeding for far longer periods than is advisable or even possible in civilised towns where the diet is cooked rather than raw, and as the character of the diet changes during the process of racial evolution so the possibilities of a prolonged lactation diminish. I found that the Japanese sailors—a large number of whom were in our command in the Mediterranean—now prefer at all times to get European food and drink if it is possible, and I learnt from Fleet Surgeon Wokatsuki, H.I.J.M. Navy, who was medical liaison officer at Malta, that with the gradual adoption of Western customs, which is slowly taking place in Japan, the old methods of feeding by breast for two or three years are disappearing. There are many grasses, herbs, and roots which contain Fat-Soluble A., and it is possible that the presence of these in the diets of primitive races allows of a longer lactation than is possible in a preserved-food type of community. As Dr. Maxwell Williamson said to me the other day in Edinburgh—speaking of the Canongate Ward in that City, of which he is Medical Officer of Health—"Tinned foods seem to form a part of their lives, and for the children the game of "kick-the-can" is the result of the litter of the street."

But to write of the baby's feeding bottle as "the dreaded bottle" is of course absolute nonsense. Even so does enthusiasm lead to fanaticism. Ireland is not alone in that respect. The baby's bottle is only a danger when it is dirty, when it contains dirty milk in the hands of a dirty mother, and when the directions as to the type of food, the method of feeding and the correct "balance" of the diet are in other hands than those of an experienced medical officer.

It is for this reason that I prefer to counsel the retention of the milk distribution at the Welfare Centre rather than relegating it to the Office for Poor Law Relief. The matter only requires honest supervision. The food department of the Ministry of Health will make themselves responsible for the correct composition of the milk supplied, and the more firms competing for contracts the better, the lower will be the contract price, and the cheaper the dried or fresh milk to the poor mother with the large family of school age.

I fear, Sir, that I have tried both the limit of your patience and your space for correspondence. Some day in the future when you are short of copy I hope to offer you the abstract of a report upon the relative importance of diet and environment as causative factors in rickets, which with the approval of the Medical Research Council will be issued as an official publication. The work has included investigation as to the type of home, air space and sleeping accommodation, overcrowding, income, rent, ventilation, cleanliness, occupations both male and female, and a study of the food of the home rather than the diet ordered at hospital or Welfare Centre. If I say that the Lady Visitors who have been working with me are, Miss Evelyn Densham, R.R.C., formerly Assistant Matron Guy's Hospital, Miss Joan Lyons, R.R.C., formerly Sister Mary, and Miss Hilda Vine, formerly Sister Charity, many of your readers will understand the wholehearted energy, and the expert knowledge with which the perplexing difficulties of industrial life have been studied by them over a most unfortunate area of London.—I am, Sir,

HAROLD CORRY MANN.

25, Harrington Gardens,
South Kensington.

Diseases of the Gall Bladder.

DEAR MR. EDITOR,—

In this letter I venture to give a brief account of the current views of American Authorities on the pathology, diagnosis and treatment of gall bladder disease, which I hope may be of some interest.

PATHOLOGY.

Among the pathological problems connected with this subject, the relation of chronic inflammatory changes in the gall bladder to similar changes in the liver, and more especially in the pancreas is one that has lately received a great deal of attention.

It has long been known that pancreatitis is a complication of cholelithiasis, but only recently has its frequency been realised.

In the Mayo Clinic, since the institution of a routine examination of the pancreas, it was found that of 1,290 cases of chronic cholecystitis, with or without stone formation, 347 had an associated pancreatitis, *i.e.*, nearly 27 per cent. There was nothing in the history of these patients to suggest the condition and the diagnosis was made at the time of operation, the head of the pancreas usually being palpably enlarged although in some cases there was found a diffuse granular change throughout the body of the gland.

It has been generally supposed on the explanation first advanced by Opie and Mayo Robson some years ago, that such changes in the pancreas were due to a regurgitation of bile along the pancreatic duct and this necessitated the occlusion of the biliary papilla, either by the impaction of a stone or by intractable spasm (Archibald's theory), and an anomalous arrangement of the ducts as they opened into the ampulla of Vater. Lately, however, evidence has accumulated to show that, although these may be the essential factors in a small number of cases, the cause of chronic pancreatitis must be otherwise explained.

In the first place the condition may be found in the absence of stone formation, as was shown in the above mentioned series of cases. In a series of anatomical studies by Judd it was found that in only about 4 per cent. of the bodies examined were the ducts so arranged as to allow regurgitation of bile along the pancreatic duct.

In the experimental work of Mann it was demonstrated that the pressure in the common bile duct in dogs was rarely high enough to cause regurgitation, even when the biliary papilla was occluded, and these factors seemed to show that the majority of cases of chronic pancreatitis could hardly be explained on such theories.

Deaver and others have recently expressed the view that infection of the pancreas follows that in the gall bladder by way of its lymphatics which freely anastomose around the head of the gland, and this view is now generally accepted.

In considering the practical importance of this factor, it becomes evident that for the successful treatment of chronic pancreatitis removal of the gall bladder is essential whenever possible, as no amount of drainage can be expected to remove such a focus of infection. At the same time this does not preclude the advisability of draining the common duct, should this be necessary.

Graham has recently called attention to the incidence of hepatitis in gall bladder disease, and in 87 per cent. of his cases found that the liver was definitely enlarged.

Other authorities have been unable to confirm the presence of similar macroscopic changes, except in a few cases, but in the Mayo Clinic microscopic changes in the liver were very frequently observed, and the general impression is that few cases of chronic cholecystitis are uncomplicated by hepatitis, although this is generally in its early stage.

It has long been known that there is a free lymphatic anastomosis between the liver and the gall bladder, and infection in one may easily spread to the other. Although it is impossible, at present, to say definitely whether the hepatitis is primary or secondary, it appears more likely that the infection starts in the gall bladder and spreads to the liver.

Diagnosis.

1. History.
2. Physical examination.
3. X-ray examination.
4. Laboratory examination.

The History, is at present the most valuable asset of the clinician in the diagnosis of chronic cholecystitis, but since there is a close physiological and pathological relationship between the gall bladder, stomach, liver and pancreas it may be very difficult, without careful investigation, to determine from the manifestations of any given symptom complex which of these organs is the one primarily involved. Dividing the cases according to the history, there appear to be four types:—

1. Those having recurrent attacks of colic, with intervening periods of good health.
2. Those having recurrent attacks of colic, with continued dyspepsia between the attacks.
3. Those with "chronic stomach trouble" and occasional attacks of sub-acute cholecystitis.
4. Those with "chronic stomach trouble" with no history whatever pointing to the gall bladder.

In the Mayo Clinic it has been found that 77 per cent. of the cases of cholecystitis with stones occur in women, and about 90 per cent. of them have had children, and experienced their first attack in close relation to a pregnancy. This is usually accounted for by the increased cholesterol content of the blood during pregnancy. It has also been found that cholecystitis without stone formation occurs in women twice as often as in men.

Physical Examination.—If the gall bladder is palpable, the liver enlarged, or the patient jaundiced, the physical examination is diagnostic, but in the fourth type of case mentioned above where the patient complains of "stomach trouble" the physical examination may give little or no evidence of gall bladder disease.

X-ray examination in these cases will exclude a gastric, and generally, a duodenal ulcer, but will only give direct evidence in a very small proportion of cases, when complicated by stones. In discussing the value of X-ray examination in the detection of gall stones, Thurstan Holland, in the *Medical Annual* of this year states that "with proper technique they should be shown when present and looked for, in at any rate 40 per cent. of the cases." This does not appear to be the experience of the radiologists in this country, and Carman with the vast experience of the Mayo Clinic is of the opinion that gall stones when present cannot be detected in more than 10 per cent. of the cases; "to place too much reliance on X-ray diagnosis of gall stones would be a backward step of many years." (W. T. Mayo.)

Laboratory Examination.—A new method of examination based on the use of magnesium sulphate and the duodenal tube has recently been introduced by Lyon of Philadelphia, which, although only in its experimental stage, promises to furnish additional and perhaps valuable aid in the diagnosis of gall bladder disease, and is not without therapeutic possibilities.

It was discovered by Meltzer, some years ago, that magnesium sulphate in the duodenum causes a relaxation of the sphincter of the biliary papilla, and a contraction of the plain muscle of the gall bladder, followed by the passage of bile into the duodenum.

Basing his method on this discovery, Lyon proceeds as follows:—

The patient is examined in the fasting state, the mouth having been previously rinsed with an antiseptic solution. A sterile duodenal tube is passed into the stomach and its contents aspirated and examined with special attention to the cells, leucocytes and bacterial flora present. The stomach is then washed, and, with the aid of a drink of water the tube is slowly swallowed until it passes into the duodenum, this usually taking about 45 minutes. On being certain that the tube is in the duodenum, a little air is injected to distend its walls and prevent trauma. The tube is now connected to a sterile aspirating bottle and gentle aspiration is begun.

In the fasting state of the normal duodenum, the sphincter of the common bile duct should be closed and the duodenal contents should be free from bile, pearly gray in colour and fairly transparent.

The first bottle is then detached for examination of its contents. Fifty to a hundred cc. of a sterile 25 per cent. solution of magnesium sulphate are

now introduced into the duodenum and a second aspirating bottle attached to the tube.

Bile usually appears after a few minutes, light yellow in colour, and diluted by the solution in the duodenum; as the colour deepens the sample collected is removed, and the bottle being re-attached, aspiration is continued.

The next sample is dark, viscid and concentrated, and comes from the gall bladder, but in the following sample it is thinner, and more yellow in colour, and comes from the liver itself; at this point the flow of bile is intermittent as it passes downwards from the bile canaliculi.

In pathological states the bile is more viscid than normal, contains an excess of mucus, and is usually turbid. On cytological examination it is found to contain pus cells, and occasionally red cells, while cultures may show pathogenic organisms. This method of examining the bile, as an indication of the state of the gall bladder, has been used in the Crile Clinic with promising results. It is interesting to note that in one of Lyon's cases the method was successful in recovering three small faceted stones, and this suggests the possibility of treating a small number of cases on these lines. It is clear, however, that this can only be a palliative measure at the best.

In a few cases of simple catarrhal jaundice antiseptic solutions, such as silver nitrate 1 in 10,000, have been instilled into the duodenum with satisfactory results.

Treatment.

(Cholecystectomy and Cholecystostomy).

With the advent of a broader conception of the pathology of gall bladder disease the choice of operation has almost ceased to be a matter of dispute and removal of the gall bladder is everywhere regarded as the ideal and logical procedure whenever circumstances permit, and here, as in other fields of surgery, the tendency is to discard the palliative in favour of the radical.

In the early days of gall bladder surgery the attention of the surgeon was concentrated on the gall stone, which, it has since been recognised, is always secondary to chronic cholecystitis and probably complicates less than 50 per cent. of the cases (Mayo). Drainage of the gall bladder, although it relieved the patient of his acute attacks of colic, did not prevent the continuation of the reflex gastric symptoms present before the operation, which are now known to be those of chronic cholecystitis, the reformation of stones, or the onset of carcinoma; while it left the fundus of the gall bladder attached to the abdominal wall causing, in many cases, permanent discomfort and distress. Finally it permitted to remain a focus of infection, from which the tissues of the body were intermittently flooded with toxins.

Crile gives the following indications for cholecystectomy:—

1. If there has been an acute cholecystitis.
2. If there is a stone in the cystic duct at the time of operation.
3. If the cystic duct is hard and thickened showing the former presence of a stone.
4. If the wall of the gall bladder is thickened.

These indications, it will be seen, include most of the conditions found in those cases which warrant operation. Briefly, the indications usually given for removal of the gall bladder, resemble a resumé of the various pathologies to which it is subject. The indications for drainage of the gall bladder, in general are based on some complication, such as pancreatitis, or on the condition of the patient which necessitates the minimum surgical interference. It is hardly necessary to point out, however, that if the pathology of pancreatitis mentioned above is the correct one, cholecystectomy is the only logical treatment. If, on the other hand, it is due to spasm of the biliary papilla, as was suggested by Archibald, cholecystectomy is also the correct treatment, since it is known that after removal of the gall bladder, the common duct undergoes a compensatory dilatation, and the increased pressure paralyses its sphincter. (Judd).

If drainage of the biliary apparatus is necessary, a cholecystostomy would seem to be the least effective method, since not only is a biliary fistula inadequate for free drainage, but this in itself promotes chronicity of infection in the gall bladder (Deaver). Choledochostomy is preferable.

Technique.

Regarding the incision C. H. Mayo uses a modification of the Kocher incision, but in the Clinic generally a right rectus incision is very commonly employed.

Crile in most of his work in the upper abdomen uses a transverse incision a few inches above the umbilicus, dividing the right rectus, and if necessary the left.

All authorities insist that the right border of the gastro-hepatic omentum should always be opened to ascertain the exact relationship of the ducts and vessels, in view of the fact that anomalous arrangements of these structures are relatively frequent. Crile aspirates the contents of the gall bladder before removing it, and says that this facilitates the operation.

Mass ligature of the stump is unanimously condemned, and the stump should not be buried retroperitonally, since the retroperitoneal tissue is far less capable of dealing with sepsis than is the peritoneum.

There is a growing tendency, both here and at other surgical centres in this country, to dispense with abdominal drainage, after cholecystectomy, except in special cases. The omission of the tube has been found to make the convalescence of the patient easier, and avoids the possibility of post-operative hernia, although in incisions of the transverse and Kocher type this is not often seen. C. H. Mayo has practiced this modification of technique in a large number of cases, and finds no cause for apprehension. The most serious objection to the tube is the fact that it causes the formation of adhesions and these have been found to be the chief factor in the recurrence of symptoms, after removal of the gall bladder, while there is a general feeling that there has been, in the past, no adequate reason for draining all cases, as has generally been the rule. C. H. Mayo in discussing the point says "abdominal drainage is indicated only in conditions in which it would be used in the surgical treatment of other abdominal disease."

Great care is taken to avoid, as far as possible, the formation of adhesions, and having covered the exposed area on the liver, it is usual to cover the front of the duodenum, the operator passing his needle alternately through the right border of the gastro-hepatic and gastro-colic omentum. If a tube is necessary it is placed between the liver and the fat, and not between the liver and the pylorus. This manœuvre evidently is not always followed by the desired effect, as can be appreciated by the experience of a surgeon in another clinic who, a few weeks after his original operation, had to perform a gastro-enterostomy for severe pyloric stenosis.

Stone in the Common Duct.

The prognosis in these cases is usually regarded as unfavourable owing to the jaundiced condition of the patient, and the presence of biliary infection, which greatly increase the risks of the operation.

In such cases operation should be postponed until the condition of the patient can be improved, but when operation is unavoidable, the patient deeply jaundiced, and the clotting time of the blood is dangerously prolonged, it is customary to give transfusions of whole blood, both before and after operation. This is of much greater value than the injection of calcium, the effect of which is only temporary.

In operating it is usual to deal with the obstruction first, leaving cholecystectomy for a more favourable occasion. If, however, the obstruction in the common duct shows signs of being permanent, the gall bladder must of course be kept for anastomosis, unless some plastic operation on the duct is possible. In these cases most surgeons emphasise the necessity of:—

1. Draining the incision made in the common duct, and of 2. Draining the abdomen down to the line of suture, but the question has recently been raised by Richter of Chicago whether drainage of the common duct is necessary in all of these cases. He points out that the common duct is in itself a suitable drainage tube, and provided that its patency can be assured, is an ideal medium by which the affected parts above can be drained; under these circumstances he maintains that the duct can be opened and closed with impunity.

Crile in discussing this subject gives the following conditions as contra-indications to such a procedure:—

(a) If there has been a stone in the biliary papilla.
(b) If the mucosa of the duct has been so injured as to cause hæmorrhage.
(c) If the duct is likely to become closed by post-operative œdema.

Since one or more of these conditions are fulfilled in nearly every operation on the common duct, it would seem that the conditions under which the duct can be closed rarely arise.

Recurrence of Symptoms Following Operation.

In the Mayo Clinic in a series of over two thousand cases, it was found that 11 per cent. of the patients had undergone a previous operation on the gall bladder or bile ducts.

Deaver estimates that nearly two thirds of all such operations are due to failure of the surgeon in the first instance to remove the gall bladder, but recurrences do follow, even after removal of the gall bladder, the chief factor in such cases usually being one of the following:—

(a) Adhesions.
(b) The presence of a stone or stones in the ducts.
(c) Pancreatitis or hepatitis.

Deaver considers adhesions are the most common of these, especially those that bind the duodenum to the under surface of the liver, producing in some cases a pyloric stenosis, and sometimes necessitating gastro-enterostomy.

In the majority of cases the stones found at the second operation have been overlooked at the first, although there is a prevalent impression that stones, especially small soft stones, may reform in the ducts. It is possible, however, that during the manipulation of the common bile duct they may have been pushed upwards beyond the reach of the surgeon. There seems no doubt that pancreatitis may cause recurrence of symptoms in some cases, or rather the persistence of symptoms, since involvement of the pancreas was probably not recognised at operation. Judd in a recent small series of cases of this type found no cause for the symptoms complained of by the patient, on exploring the abdomen after cholecystectomy. He placed a tube in the common duct, and after prolonged drainage the patients were completely relieved. This raises the question of the possibility of recognising the symptomatology of pancreatitis before operation, and treating it by drainage of the common duct in the first instance.

The problem of how to deal with the gall bladder is regarded as settled; the problem of when and where not to drain the biliary apparatus is more comprehensive and more important.—I am, Sir, yours, etc.,

GRANT MASSIE.

The Mayo Clinic,
Rochester, Minn.
October 1st, 1921.

Foreign Bodies in the Food and Air Passages.

CLINICAL LECTURE BY MR. W. M. MOLLISON.

GENTLEMEN,—The question of Foreign Bodies has been recently brought prominently before us in the Throat Department by the occurrence of a rare fatality as the sequel of a very common accident, that of the swallowing of a coin by children.

A child of two years of age swallowed a halfpenny; two days later he was seen in the Throat Department; the usual treatment was carried out, an anæsthetic was administered and an œsophageal tube passed; the tube used is a Hill's tube and in but few cases does it need to be passed further than the post-cricoid space to disclose the coin; suitable forceps then grasp the coin which is removed through or with the tube. On this occasion the child was noticed to take the anæsthetic badly, he was pale and his respirations rather fast. Examination through the tube revealed the coin, but it was lying in a collection of frothy mucus, and on account of the child's condition it was thought better to stop the operation till this improved; accordingly the child was admitted. Instead of improving he became worse, the respirations rose to 40 per minute, and in a few hours the child was dead.

At the autopsy the halfpenny was found to have ulcerated through the œsophageal wall into the pleural cavity; there was an empyema and broncho-pneumonia.

I do not know the number of cases of "coin in the œsophagus" that are seen at the Hospital a year, but at a conservative estimate it must be two a week; during the last ten years I do not call to mind one case where death occurred from ulceration of the œsophagus by a coin.

Foreign bodies in the food passages may lodge at any level, the site of lodgement depending to some extent on the shape and size of the object. The food passage may be divided into three parts:—

1. The mouth and pharynx.

2. The hypo-pharynx.

3. The œsophagus, beginning at the lower border of the cricoid.

1. It is obvious that only very large masses will stick in the pharynx, and the resulting obstruction to respiration will necessitate immediate action to remove the mass (? of food) either by the finger or forceps if at hand.

The common foreign body that sticks in the pharynx is a fish bone; the usual site is in the tonsil, indeed in nine cases out of ten when a patient complains of a bone "sticking in the throat," the bone will be found in the tonsil. It is often necessary to examine very exactly before the bone can be seen, as its colour is nearly that of the tonsil and as it may be buried deeply.

Other positions in which the bone may lodge are the back of the tongue, the vallecula or the pyriform fossa. Recently we saw a case of a bone an inch and a half long sticking vertically in the lymphoid tissue at the back of the tongue.

Should the fish bone remain in position it will tend to cause inflammation, and perhaps pricks by foreign bodies may be the origin of those serious cases of acute parenchymatous glossitis and abscess in the tongue. It is usually considered that inflammation follows a few days after lodgement, but in one case no reaction had followed, though the bone had been in the tonsil three weeks.

2. The hypo-pharynx is the most likely place of lodgement of foreign bodies; it is a potential space, only opening to allow the food bolus to pass; it is bounded by the cricoid and arytenoids in front, by the vertebral column behind.

It is in this space that foreign bodies frequently lodge; smooth objects like coins do little harm, but bodies with projections may cause damage by ulceration of the mucous membrane over the cricoid or arytenoids and so lead to perichondritis and stenosis of the larynx.

The following case illustrates these complications and demonstrates the great importance of early removal of foreign bodies.

A soldier was eating rabbit stew when a bone stuck in his throat and he found he could not swallow any more; even fluids were a great difficulty and caused much pain. Various attempts were made to help him, but only with unsuitable instruments; it was gradually realised that the man was becoming ill, his temperature rose to 102° and he developed a

cough. He was transferred to England and I saw him on the sixth day after the accident. The man was ill, his temperature swinging to 102° and 103° in the evening; he had a cough and was bringing up a good deal of sputum. He could swallow nothing except sips of water.

Under an anæsthetic a tube was passed and with great difficulty a piece of bone was removed, with difficulty because it was almost buried in swollen mucous membrane. The bone proved to be a complete rabbit's vertebra. Subsequently he swallowed normally, but the ulceration progressed to perichondritis of the cricoid with the result that stenosis of the larynx developed and tracheotomy was required. There is no doubt that early removal of this rabbit bone would have led to recovery.

Occasionally foreign bodies may be of such a shape as to rest transversely across the mouth of the hypo-pharynx.

The following case illustrates this point: A soldier was seated on a bench darning his socks, he held the needle in his mouth while preparing a fresh piece of wool; at that moment the bench tipped up, and in his surprise he swallowed the needle which stuck in his throat. Examination with a tube showed the needle lying transversely at the level of the upper parts of the arytenoids, both the ends embedded in the mucous membrane; removal was not difficult except that the sharp end had to be disengaged by pushing the blunt end a little further into the mucous membrane.

Never disregard history of swallowing of foreign bodies; it is easy to look with a short tube; when the patient complains of much difficulty or of pain on swallowing fluids the foreign body is probably damaging the mucous membrane of the œsophagus. Recently a mother brought her child to the Throat Department complaining that he was not swallowing his milk properly, but was vomiting, and this for the past 48 hours. Examination with the tube revealed a triangular piece of glass lodged just below the cricoid. Smooth objects may main in the gullet for long periods and only give rise to dysphagia from time to time. In one case, that of a small tooth-plate whose curve fitted that of the œsophageal wall, the body was removed three years after it had been swallowed.

Difficulty in swallowing even moderate sized mouthfuls is a natural condition with a certain number of persons, particularly women, and should one of them swallow by mistake a too large mouthful, complete dysphagia results. A few months ago a woman presented herself in the Out-Patient Department with severe dysphagia of 48 hours 'standing. Even with the laryngeal mirror a foreign body could be seen behind the arytenoids. This was a piece of meat that the patient had tried to swallow. She said she always had to be careful not to take large mouthfuls, and this one had slipped down accidently. Treatment consisted in passing a short tube with the intention of removal, but the mere introduction of the end of the tube into the upper part of the hypo-pharynx was enough to dislodge the meat, which then slipped down with the greatest ease.

3. Once past the hypo-pharynx foreign bodies may lodge in any part of the œsophagus, depending to some extent on their shape and size. Naturally smooth objects will tend to pass further, while tooth-plates with hooks will be delayed as soon as the hooks grip the mucous membrane. The symptoms of the presence of a foreign body in the œsophagus are dysphagia more marked for solids than liquids and dynphagia of some degree (pain in swallowing).

There is some factor in addition to the mechanical one that causes dysphagia to follow the swallowing of a foreign body; thus some bodies are so small and of such a shape that food ought to be able to pass down beside them, but, as a fact, this does not happen. On one occasion I have seen a plum stone resting at the lower end of the œsophagus, causing complete dysphagia, and yet the mere attempt to grasp it with forceps caused it to slip through into the stomach. No doubt in this case the presence of the stone irritated the wall of the gullet and interfered with the neuro-muscular mechanism and so prevented food from passing.

The size of the foreign body is sometimes astonishing and makes it difficult to understand how it got past the hypo-pharynx. A cobbler was repairing a boot, holding in his mouth one of those round rubber heels; unfortunately he was an epileptic and chose this moment in which to be seized with a fit; on recovering from the fit, the heel had disappeared and swallowing was difficult. Examination showed the heel in the œsophagus about halfway down, and it was removed whole by withdrawing it with the tube.

The nature of foreign bodies varies greatly, but is not of any great interest except in so far as it makes removal easy or difficult. In the case quoted above of the rabbit's vertebra the sharp processes, by becoming embedded in the wall of the passage made removal more difficult than in the case of a smooth object like a coin. Tooth-plates by reason of their metal hooks, may present great difficulties. To overcome these difficulties Irwin Moore has devised an excellent pair of shears with which to cut the plate into two or more pieces.

It is to be noticed that in some cases of carcinoma of the œsophagus, the swallowing of a hard or tough substance may give rise to the first attack of dysphagia. On one occasion a man was admitted suffering from almost complete dysphagia of a few days' standing. Examination with a tube revealed two or three grape skins resting on the top of a carcinomatous stricture; after removal of the skins the patient was able to swallow quite well.

So far solid bodies have been considered, but liquids may be foreign bodies and produce results equally important, though delayed in their action. Corrosive fluids, if swallowed, pass quickly to the lower end of the œsophagus get delayed there a short time before passing into the stomach and so cause damage to the mucous membrane. Should the patient recover from the immediate effects of the poison, scarring of the last few inches of the œsophagus takes place and the stenosis so produced demands treatment subsequently.

When there is serious doubt as to the presence of a foreign body, examination of the œsophagus must be undertaken for diagnostic reasons, since serious complications may arise if removal is not effected. It follows, therefore, that diagnosis and treatment are intimately connected. It is true that various instruments have been devised for the blind removal of foreign bodies, the coin catcher by means of which coins are drawn up and the probang by which small or irregular objects can be swept up or even pushed down; this latter should be discarded altogether as brutal and dangerous. The coin catcher is not so dangerous and may still be used for recently swallowed coins or flat buttons, but even so it must be used with the greatest gentleness; no doubt in the absence of œsophageal tubes it is a valuable instrument.

Sometimes very simple means will suffice to dislodge the body, swallowing mouthfuls of bread or dough may drive a bone down to the stomach; in the case of a child vomiting may be induced which may result in the expulsion of a coin, but it is obvious that if the foreign body is fixed by hooks, blind attempts at removal may do irreparable harm. Nowadays inspection of the œsophagus can be carried out by means of tubes. Down these tubes light is reflected from a mirror-proximal illumination, or light is supplied by a small lamp carried at the end of the tube—distal illumination. There is no comparison between the two methods of illumination; the distal gives a far better view of the œsophagus and has the additional advantage of leaving the proximal end free for the passage of instruments; the disadvantage lies in an obscuring of the light by mucus or blood, but this can be easily overcome by the use of some suction apparatus.

Here are specimens of the tubes used in our department; this narrow one is that designed by Chevalier Jackson; it is possible to pass it after applying cocaine to the pharynx and larynx. This larger one, oval in section, is Mosher's tube; it is meant to be passed with this plunger at the end till past the cricoid, but I have had the end cut off obliquely so that I can see the end entering the hypopharynx, a distinct advantage. Here, too, are some forceps for grasping the foreign body; this one is Irwin Moore's.

Foreign Bodies in the Air Passages.

Inhalation of foreign bodies may lead immediately to most alarming symptoms, and, indeed, in some cases to sudden death. It is interesting to note, however, that if the initial symptoms are recovered from, the foreign body may remain for long periods in the air passages and be tolerated for months or even years; a toleration is scarcely possible by the œsophagus, so that the ultimate prognosis (in the absence of treatment) is better for foreign bodies in the air passages than in the œsophagus.

Although this is so, it does not mean that treatment is to be delayed, far otherwise, for reasons which will be put forward.

Foreign bodies may lodge in the larynx or pass through the glottis to the trachea or bronchi; they may pass on further to the secondary bronchi. Should the body lodge in the larynx it is likely to cause sudden death from suffocation or from spasm of the glottis. In the Mu-

seum there is a specimen showing a child's larynx with a small piece of bone between the cords; here is the specimen and you will see that the piece of bone is so small that it did not cause death by preventing the entrance of air mechanically, but must have done so by causing the cords to contract spasmodically; it is possible that in addition a reflex inhibition of respiration occurred.

Cases are known in which a foreign body remained lodged between the cords for some days before causing death; in one case the body was a collar stud; it was, as it were, "buttoned" into the glottis, the edges of the cords acting as the edges of the button-hole. The child suffered from dyspnœa and was considered to be a case of diphtheria; only at autopsy was the cause of death discovered.

It is obvious that treatment in these cases of foreign bodies lodged in the larynx must be immediate. It consists in making attempts to dislodge the body by any means at hand; children can be held in an inverted position and shaken or given blows on the back; should these measures fail, laryngotomy must be performed. Should, by any fortunate chance, instruments be at hand, direct inspection of the larynx could be carried out and the object removed by means of forceps; from the nature of these accidents it is exceedingly unlikely that such would be possible, it is far more likely that the doctor called in would have to perform a hasty laryngotomy or tracheotomy.

When the foreign body passes through the glottis it is still dangerous, because it may be coughed up to the cords and lodge in the glottis on its way out, as it were, and again cause spasm. Of course, it is possible for the body to escape through the glottis, and in the days before the direct vision tubes were invented many such recoveries were recorded.

The severity of the symptoms that follow the retention of a foreign body in the bronchi (or more rarely in the trachea) depends to some extent on the nature of the body. Small metallic bodies cause the least damage, indeed, cases have been recorded of needles remaining in the bronchi for years and eventually being coughed out (Gross). On the other hand, soft objects like almonds or pea-nuts are almost invariably fatal if left in the lower air passages for more than a few hours. Roots of teeth occasionally are inhaled during extractions and since these are frequently septic, they are among the most dangerous of inhaled bodies.

The symptoms produced by foreign bodies in the air passages may be divided into three stages :—

1. *The Initial stage.* — Contact of the body with the delicate mucous membrane of the respiratory tract causes cough of a spasmodic nature; the period over which the cough persists will depend on the rapidity with which the body passes to the lower parts of the air passages and becomes fixed. In those cases in which the body passes into the trachea and is of such a shape and nature as to remain in this tube rather than pass on to the smaller tubes, the cough is likely to persist by reason of the body being blown up against the cords in expiration.

2. *An Irritative stage.*—The mucous membrane does not tolerate the contact of a foreign body, particularly if that body is septic, with the result that the secretion of mucus occurs; this results in expectoration which tends gradually to become muco-purulent and later purulent. During this stage the patient is apt to develop symptoms of general infection, an evening rise of temperature, lassitude, loss of appetite.

3. *An Infective stage.*—Owing to the infection of the bronchi and lungs, bronchitis, broncho-pneumonia, abscess in the lung, bronchiectasis may occur. In the majority of cases in which the foreign body remains long enough to give rise to these complications, the prognosis is very bad, death usually occurring in a few days or weeks. Cases are, however, known of patients who suffered from cough and expectoration of many years standing and were diagnosed as phthisis, but who then coughed up a foreign body and recovered completely.

The symptoms consist of cough and expectoration combined with a temperature septic in type; the expectoration is foul, as in all infective lung conditions. The signs will vary with the lesion present, being either those of a broncho-pneumonia confined to one side of the chest or to one or two lobes of a lung; or there may be indications of a bronchiectatic cavity. A radiogram of the chest will help in the diagnosis.

An important sign which may be found at an early stage is that due to blocking of one bronchus by the body, the left bronchus is more

often entered by the body, so that the appropriate signs are to be found on that side; the whole lung may be dull and breath sounds absent or the signs may be confined to one lobe only. The foreign body may pass into a bronchus and act as a ball valve allowing air to leave but not enter that lung or lobe.

Again, in connection with foreign bodies in the air passages emphasis must be laid on the importance of *history*. Never disregard the mother's account of the onset of symptoms in her child, sudden cough while playing with some toy and inability to find the toy later, cough of sudden onset and unexplained origin, cough after "swallowing" something, even though at the time of examination the child seems perfectly well.

The treatment of foreign bodies in the air passages is summed up in one word—removal. From what has been stated earlier, the sooner removal is undertaken the better even though examples are known of bodies remaining in the bronchi for months without ill effects. Removal can be effected by withdrawing the body through the glottis. This is carried out by means of the direct laryngoscope, or more often the bronchoscope; the former is only of use for bodies lodged in the larynx; many of you are familiar with it when used to pass the catheter for the administration of ether given intratracheally. Here is Jackson's tube for passing into the trachea; it has a very narrow lumen, is quite small, illumination is by means of this lamp at the distal end. Special forceps are needed to pass through the tube; here is a very ingenious pair, but reliance must not be placed on one pair only, as different jaws will be needed on occasion depending on the type of foreign body.

The tube is passed through the glottis after the application of cocaine to the larynx, the body is found in one of the bronchi, forceps are passed, and the body grasped and removed. This sounds a simple proceeding, but is not always so in practice. It is certainly easier to give a general anæsthetic even though a slight risk is run in severe cases of long standing.

A careful X-ray showing the body from two or more directions is helpful, and in some cases the tube may with advantage be passed under the guidance of the X-rays. If the body has been in situ for some time, application of adrenalin to the mucous membrane will be needed to counteract the inflammatory swelling and to check a tendency to hæmorrhage.

Cases will occur in which all attempts through a tube will fail, and a low tracheotomy should then be performed and a tube be passed through the wound. Since the tracheal lumen is so large, a tube with a greater diameter can be used than that passed through the glottis, also a tube passed direct into the trachea has much less distance to go to reach the bronchi; both these facts make the manipulations of delicate instruments a good deal easier; after removal of the body the tracheotomy is closed.

Sir Alfred Fripp's Address to the Physical Society.

An Appreciation.

DEALING with the old guides to well-living that have come down through the ages, Sir Alfred clothed them anew in a dressing harmonising with the times in which we live.

Few would have dared attempt such a discourse, fewer still would have succeeded, and no one could have put the theme quite in the same way; it was cast in a mould typical of the man. It had a sporting atmosphere. He led along the Way of Life, marked each cross road with some arresting quotation, directing the wayfarer in the right path. In his inimitable manner he dotted the way with bright lights of humour, to show how happiness may be preserved along the roughish track.

Uplifting all the way, he gave wise advice as to the preservation of faith, and ended on the highest note, of trust in God. It was a truly remarkable address, earnest, impressive and yet slashed with bright and witty sayings, not got up for the occasion; such thoughts could only come from the deep wells of reflection and conviction.

Those who did not hear this address missed a great treat, for the reading of it will be shorn of the personal charm, and the adornment of expression. Who can forget the "got that?" and the pause of just the right length?

SENEX.

Change of Address.

D. Jones, M.R.C.S., 5, Cathedral Road, Cardiff.

A. J. K. Drew, 2, Chapel Place, Ramsgate.

G. N. Stuart, "Wentworth," 164, London Road, Leicester.

The Tuberculous Mother and her Child.

CLINICAL LECTURE BY DR. GEOFFREY MARSHALL.

GENTLEMEN,—Pulmonary Tuberculosis is, as you know, a disease which shows its heaviest incidence amongst young adults. According to the statistics of the Registrar General, of the women who die between the ages of fifteen and twenty-five years, more than a third die of tuberculosis. From the latter age onwards the mortality rate falls in single women, but in the married ones who bear children this toll goes on unabated into the fourth decade. Here we have evidence that the disease is more common, or at least more fatal, in women who bear children, and when we go into the histories of our cases of phthisis we find that a high proportion of the married women date the onset of their symptoms from the latter end of a pregnancy. Curiously enough, the ill-effects of pregnancy on cases of phthisis were not recognised by the early medical writers. From the time of Hippocrates down to Sydenham, and even in the early years of the last century, it was taught that a tuberculous girl should be urged to marry, one of the arguments being that the increased sexual appetite which is a feature of the disease was Nature's guide to treatment, and that a pregnancy would bring about an abatement of the symptoms and perhaps an arrest of the disease. The teaching has now swung to the other extreme, and many authorities now advise that pregnancy in a patient with pulmonary tuberculosis should invariably be terminated during the first three months; for while it is true that the condition often seems to improve during the first few months of the pregnancy, a fatal exacerbation is not uncommon about term or during the months that follow.

In the tuberculosis department here we have had the advantage of working in collaboration with the Salomon Centre, and have had under observation during the past two years a number of phthisical women before and after childbirth. Of our first twenty cases we have lost one. She was a girl of 19 years who came to the tuberculosis department with signs of a generalised bronchitis, tubercle bacilli were found in the sputum. With rest in bed her temperature became normal, and arrangements were made to send her to a sanatorium. She then announced that she would not go away, but was getting married instead. All persuasion was in vain. She got married, became pregnant, refused further treatment, and died before the end of the pregnancy. Of the remaining cases the pregnancy has been artificially terminated in three, the rest have gone safely through, giving birth to apparently healthy children. Our practise is to keep the expectant mother under careful observation, especially as regards temperature range and weight. Should there be pyrexia or loss of weight, the patient is rested in bed, and as a rule, after a week or two the symptoms will abate. Only when rest fails to abolish the pyrexia and wasting do we advise artificial termination of the pregnancy. During the first three months abortion may be induced by the ordinary methods, but if the pregnancy has to be terminated later than the third month this slow process of induction should not be used, it commonly gives rise to an exacerbation of the pulmonary disease. In these cases the uterus should be emptied by the rapid open operation through the abdomen. This was done with excellent result in one of our cases admitted to Queen Victoria Ward under Mr. Bellingham Smith and operated on by Mr. McNair. The patient was a young married woman who came to the tuberculosis department with early phthisis, and whom we sent to a sanatorium where the disease was apparently arrested after four months' treatment. She became pregnant shortly after returning home, and as is usual in these circumstances, the disease lit up. Statistics of the King Edward VII. sanatorium show a mortality of over 90 per cent. amongst the women patients who become pregnant shortly after discharge. In general it may be said that that pregnancy is more likely to bring about a fatal exacerbation is early cases of phthisis than in the older more chronic cases of two years' standing and over. Even in the latter cases there will usually be pyrexia and increase of physical signs about term and during the puerperium, but with rest and careful treatment the process will quiet down. A fatal outcome is certain in cases complicated by tuberculous laryngitis.

Now we come to the question, should a tuberculous mother be allowed to suckle her child? Again there is a divergence of views. The popular teaching is that lactation should not be allowed. Pritchard holds that it is good for the mother, and that when the secretion of milk is suddenly stopped, her condition rapidly

deteriorates, Our experience tallies with that of Netter, that lactation is well born by the old-standing chronic cases, not by the early cases. I do not think that it ever does a phthisical woman good; to many it does active harm, as shown by fever and rapid loss of weight, which symptoms are usually relieved promptly by weaning the baby. From the point of view of the mother there is little to be said in favour of allowing lactation, but for the child's sake we encourage suckling until we find that it is doing harm to the mother. The milk is seldom infective except in those occasional cases where the woman is suffering from tuberculous mastitis, and it is important that the infant should have its natural food.

The child of the tuberculous mother.—There is a heavy mortality among the infants of tuberculous mothers, and indeed it is probable that the total mortality from tuberculosis is considerably higher than shown by statistics, for the disease is often fatal in young babies without producing lesions which are easily recognisable during life, or even at autopsy, without microscopic investigation. Landouzy showed that in children under two years of age dying of broncho-pneumonia, although there was no evidence of tuberculous disease naked eye, in a high proportion tubercle bacilli were present in the pneumonic patches on microscopic examination. Lubarsch, in the course of 600 autopsies on children two years and under, showed microscopic evidence of progressive tuberculosis in over 20 per cent.

Taking thirty-seven young married women attending our Tuberculosis Department, we find that they have given birth to 149 children during the course of their married lives. Of these 149, over a third, *i.e.*, 54 children, have died before reaching the age of two years, and only six of the 54 deaths have been attributed to tuberculosis, the remainder being certified as due to gastro-enteritis, marasmus, bronchitis, broncho-pneumonia or convulsions. I have little doubt that the bulk of this very heavy mortality is due to tuberculous infection.

How does the child become infected? Intra uterine infection can occur, as has been proved, but it must be exceedingly rare. The chief danger is doubtless the mother's saliva. The child is probably infected by inhaling the bacilli when being handled by its mother. To avoid this Grancher has organised a scheme in Paris whereby the infant is taken from its mother on the first day of life, and is brought up by foster parents. The medical results are good, but the scheme is too inhuman to become general. In our department we too have had good results, having lost only one child born during the time the mother has been under observation. Our practise is to instruct the mother as to the danger of kissing the child, of hanging over it, coughing near it or of using a common handkerchief. Moreover, each infant is brought up once a week and given a course of tuberculin injections commencing as soon as possible after birth; is this way we hope to establish an artificial immunity before massive infection takes place Vaccine treatment may be of little use after infection has occurred, but its value in prophylaxis is established on firmer ground.

Pass List.

Conjoint Board.

FIRST EXAMINATION. SEPTEMBER, 1921.

Chemistry.

P. Berry.
H. M. Doubleday.
G. E. Graham.
F. St. J. Powley.

Physics.

J. O. Barnes.
P. Berry.
P. M. Deville.
H. T. Rylanse.
H. M. Doubleday.
A. T. Brimmer.
F. St. J. Powley.
H. G. Brooks.
A. W. Reynolds.

Biology.

P. Berry.
P. M. Deville.
O. H. M. Woodbridge.
H. Kessel.
W. Nicholls.

SECOND EXAMINATION. PART I.

Anatomy and Physiology.

*G. T. Hankey.
M. Taylor.
Max Rubinstein.
J. S. Jacobsz.
A. Jewell (1).
A. Jewell (2).
R. A. Grant.
*F. M. Newnham.
H. E. Lewis.
†F. J. Levy.
J. J. Laws.
*C. H. C. White.
H. C. Warner.
B. Rubinstein.
P. S. Court.

*Anatomy only. †Physiology only.

PART II. *Pharmacy.*

R. A. Dyke.
R. F. Smith.
C. F. Morrison.
T. F. Fox.
G. B. Kirkland.
A. R. Cox.

Appointments.

Guy's Hospital Medical School.

OCTOBER, 1921.

The following Entrance Scholarships have been awarded :—

Senior Science Scholarship for University Students (War Memorial Scholarship).—£75. Bernard Graham Scholefield, Christchurch, Oxford.

Entrance Seholarships in Arts.—£100. Russell Claude Brock, Christ's Hospital.—£50. Arnim Fitzwilliam Horatio Stewart.

October 16th, 1921—January 15th, 1922.

Clerks to Medical Unit (Second three months).—(Dr. Beddard) Messrs. N. L. Eckhoff, D. B. Hitchings, N. L. Lloyd, G. D. Shaw, R. G. Tame, T. Wooldridge; (Dr. French) Messrs. R. H. Amm, F. E. Graham-Bonnalie, M. Hawke, H. Seelenfreund, F. J. Smith; (Dr. Hurst) Messrs. M. Bannounah, H. P. Baylis, O. G. Bowen, J. L. Faull, M. Killard-Leavey, M. Mitman.

Dressers to Surgical Unit (first three months).—(Sir A. Fripp and Mr. Turner) Messrs. S. P. Jacobson, G. O. Mitchell, P. Mc.G. Moffatt, A. T. W. Powell, S. C. Rowbotham, H. C. C. Taylor; (Mr. Steward and Mr. Hughes) Messrs. H. G. R. Canning, J. A. Currie, G. T. Henderson, L. G. Housden, J. Jemson, F. Newell-Roberts; (Mr. Fagge and Mr. Davies-Colley) Messrs. A. B. Aldred, T. Blacklidge, W. A. Caldwell, A. B. Davies, G. F. Gibberd, E. E. Neser; (Mr. Rowlands, Mr. Bromley and Mr. Slesinger) Messrs. W. H. Craib, D. J. T. Jeans, E. Jones, C. E. Keast, G. C. Millis, H. Myers, G. W. V. Parry, D. Vaughan.

(Second three months).—(Sir A. Fripp and Mr. Turner) Messrs. C. O. Carson, R. J. Hooker, D. H. Hubbs, H. C. Meathrel, A. F. Percy, R. M. L. Still, D. A. L. Crawshaw; (Mr. Steward and Mr. Hughes) Messrs. H. C. Beccle, H. L. Bernstein, A. Broido, R. Brooke, I. E. Harries, P. G. Harvey, J. H. M. Lloyd; (Mr. Fagge and Mr. Davies-Colley) Messrs. W. G. Booth, H. Evans, P. Hack, E. Orsmond, H. J. Plowright, D. G. Robinson, S. S. Suzman; (Mr. Rowlands, Mr. Bromley and Mr. Slesinger) Messrs. W. A. Brown, S. H. Daneel, A. Gordon, M. Weinbren, G. B. Withers, J. Woodhoues.

Obstetric Dressers, Extern, and Clerks in Children's Department.—(Mr. Bellingham-Smith) Messrs. G. R. M. Apsey, C. H. Atkinson, D. S. Davies, V. R. De Boissiere, G. E. Fisher, E. H. Koerner, J. T. Linklater, M. Markiles, G. M. Stoker, D. B. Whitlock, B. C. Woodroffe; (Mr. Chapple) Messrs. J. Atkin, S. C. Bakhle, F. J. Biddle, L. Forman, A. W. Hall, M. Honigsberger, M. Jackson, C. A. Probert, F. R. Ratnagar, H. J. F. Wood.

Dressers or Clerks in Special Departments—

Ophthalmology.—(Mr. Eason) Messrs. M. A. El-Biblawi, M. M. Hegab, and W. H. Summerskill; (Mr. Ormond) Messrs. H. A. Harris, B. L. Laver, and F. W. Widgery.

Laryngology.—(Mr. Mollison) Messrs. H. A. Harris, B. L. Laver, and H. Richards; (Mr. Layton) Messrs. B. Kessell and M. Mackenzie.

Dermatology.—(Dr. Barber) Messrs. W. G. Hore, J. S. Hudson, H. B. Jones, C. L. Kark, J. K. Milward, W. M. Ramsden, and P. G. Sedgwick.

Neurology.—(Dr. Hurst and Dr. Symonds) Messrs. H. B. Jones, M. M. Hegab, and F. W. Widgery.

Orthopædics.—(Mr. Trethowan) Messrs. I. J. Bechal, H. W. Harvey and T. E. Jones.

Genito-Urinary.—(Mr. Thompson) Messrs. H. W. Harvey and J. K. Milward.

Pathological Assistants to the Demonstrators of Morbid Anatomy.—Messrs. H. C. Beccle, F. E. Graham-Bonnalie, N. L. Lloyd and G. D. Shaw.

Clinical Assistants.—(Dr. Fawcett) Messrs. F. Bekker, W. Carling, A. H. Douthwaite, I. B. McCann, A. T. Rogers, and A. E. Strawbaum.

Clerks to Anæsthetists (October 16th—November 15th)—

Dr. Shipway—Messrs. W. G. Hore and H. Richards.

Mr. Marston—Messrs. W. M. Ramsden and D. A. Windemer.

Mr. Scott—Messrs. R. Hale-White and F. D. Howitt.

Mr. Kendall.—Messrs. P. G. Sedgwick and D. G. Sharp.

Mr. Lansdown—Messrs. V. R. De Boissiere and G. E. Fisher.

Mr. Gill-Carey—Messrs C. C. Po and J. F. Payan.

Mr. P. Scott—Messrs. C. H. Atkinson and B. C. Woodroffe.

Guy's Hospital Dental School.

OCTOBER TO DECEMBER, 1921.

Student Demonstrators of Dental Prosthetics.—Mr. F G. Davies, Mr. J. R. A. Moore.

Guy's Employees' Association.

The above Association held their first meeting of the new session in the Physiological Theatre, on Wednesday, October 19th, when Professor Pembrey very kindly delivered lecture on "How and Why We Breathe."

Mr. Croucher presided, and after apologising for the President's (Mr. Eason) unavoidable absence, introduced Prof. Pembrey to the meeting. There was a moderate attendance, due no doubt to the short notice given to members to attend. Those who turned up must, however, have been very impressed with the simplicity of the lecture. In order to make quite clear certain of the principal points the Lecturer gave a series of interesting experiments which impressed those present beyond telling.

It was pointed out that respiration was present in all forms of life. Commencing with the egg Prof. Pembrey demonstrated how oxygen managed to find its way into the egg, and how the carbon dioxide was driven out. A lung attached to a tube connected with a pair of bellows was then exhibited, and it was shown what action ordinary breathing had upon the respiratory organs. To demonstrate the value of oxygen, the lecturer instanced the case of airmen who could not go up above a certain altitude without a supply of this element. There were numerous cases on record where airmen were rendered gradually unconscious through not having sufficient oxygen in the higher altitudes. During the war airmen were issued with a mask and oxygen cylinders in order that they could ascend to high altitudes. It was also proved by an experiment with rats that a human being could be rendered quite unconscious by the rapid ascent of an aeroplane into an altitude where there was a low pressure of oxygen.

Coal gas poisoning was next dealt with and illustrated by experiments.

Prof. Pembrey stated that it was absurd how some people ran away with the idea that by inhaling larger quantities of oxygen it would bring about a better vitality. During our holiday it is the change of air, temperature, and wind, etc., which bring about the differences, and not the supposed extra supply of oxygen.

Another experiment was made by putting a rat and a candle in a confined space of air, the candle went out, but the increase concentration of carbon dioxide had no marked effect upon the rat.

Ventilation, "second wind," the action of smoking on the respiratory system, and how oxygen got into the blood was also dealt with and made clear by various demonstrations.

At the close Mr. Homphrey proposed a vote of thanks to Professor Pembrey for his extreme kindness in giving up so much time to lecture to the employees, and for the simple way in which everything was made so perfectly clear.

Mr. J. H. E. Winston briefly seconded, and the motion was carried with acclamation. Mr. Croucher, in conclusion, thanked Professor Pembrey's assistants, and a further vote of thanks was passed to Mr. Baker for preparing the material for the lecture.

It was announced that the next lecture would be given by Mr. Hopson the Senior Dental Surgeon in November. It is hoped that these lectures, with the aid of members of the Medical and Surgical Staff will continue throughout the year—it would be superfluous to estimate the value of such talks to the employees.

Reviews.

Minor Surgery and Bandaging (17th edition). By Gwynne Williams, M.S., F.R.C.S. (J. & A. Churchill.) 1920. 10s. 6d. net.

The fact that this small volume has reached its 17th edition is in itself proof of its excellence and popularity. During the sixty years that have elapsed since the first edition, many important changes have taken place in surgery, but the authors have succeeded in maintaining throughout the high standard which has caused it to outlive all its rivals.

The present edition has been revised and to a certain extent re-arranged, only those parts of war surgery being included which will prove of value in civil life.

To the newly qualified and those embarking on house appointments it would prove invaluable, embracing as it does so many practical points which are *not* included in the text-books.

Orthopædic Apparatus. By F. G. Ernst. (Whitefriars Press, Ltd.) pp. 106. 138 illustrations. Price 12s. 6d.

The primary object of this book is to give the medical profession generally some idea of what can be accomplished by the skilled orthopædic mechanician of to-day. It is divided into a number of sections, each one dealing with one particular part of the body, and Mr. Ernst's descriptions, aided by a large number of very good half-tone illustrations, show how much can be done for many patients whose cases might seem, at first sight, to be almost hopeless. Many kinds of apparatus are illustrated, but the author is careful to insist that these are only types, and that every case must be studied individually, and an instrument devised in accord-

ance with its needs. Every instrument must, of course, conform to the fixed laws of mechanics, and it must be as ingenious as an inventive mind can make it; that is where the skilled mechanic comes in; it must also be devised with due regard to the surgical aspects of the case, and for this reason the co-operation of the surgeon is always desirable. As Mr. Ernst points out in his preface, this co-operation of surgeon and mechanician is essential to the production of instruments of the finest kind, and throughout his book he repeatedly acknowledges the help that he has received from various well-known surgeons in this respect. It is much to be deplored that many practitioners are profoundly ignorant of the principles that govern the construction of apparatus, and have therefore lapsed into the pernicious habit of leaving the whole question of design to the mechanic. The chemist compounds the bottle of cough-mixture, but it is the physician who prescribes what it shall contain, and a patient who was merely told by his doctor that he had a cough, and that the chemist would prescribe for him would be very properly astonished!

The enthusiasm and the mechanical skill which Mr. Ernst has brought to his work are apparent everywhere, but it is evident that he has also thought long and earnestly about the surgical side of many of his patients, and that he has studied their complaints closely. His studies upon the causation of injury of the semilunar cartilages, for instance, are of the greatest interest, and constitute a notable contribution to the elucidation of this difficult problem. His description of the various degrees of laxity of the knee-joint, and of the importance of lateral mobility in the causation of semilunar displacement, as compared with rotatory mobility, will be new to many surgeons.

Every kind of appliance that is commonly used in the treatment of deformities, both congenital and acquired, is here described. There are sections dealing with the upper and lower extremities, the neck, the spine, the feet, and the pelvis; special sections are devoted, also, to the consideration of the knees, and of fractures, both recent, and old, complicated and uncomplicated. In the chapter on paralyses, a special feature is made of the design of closely-fitted instruments, devised so as to be as unobtrusive as possible, whilst in another section the all-important principle of relieving arthritic joints from weight-bearing obtains full recognition. There is a short chapter on belts and trusses, and the author has some interesting remarks to make upon the form and strength of truss-springs.

The book is extremely well got up; the quality of the paper, the printing, and the illustrations leave nothing to be desired, and the price is moderate.

Notices.

Medical Department of the Navy,
1, Lake Buildings,
St. James's Park,
S.W. 1.
30th August, 1921.

Sir,—

I have to inform you that the Competitive Examination of Candidates for entry into the *Royal Naval Dental Service*, arranged to be held in July last, was postponed indefinitely, there being an insufficient number of candidates who could be considered in all respects suitable to hold commissions as Dental Officers in His Majesty's Navy.

It is not practicable to arrange for the competition to be held during the current year, but it is desired to enter a limited number of officers before the 31st December next, and it is now proposed to invite the Deans of the leading Dental Schools to nominate suitable gentlemen for entry without competitive examination.

The number of such entries will be limited to nine, and they will be selected from among the nominees, subsequent to interview by the Medical Director General of the Navy, and an examination as to their physical fitness by a Board of Naval Medical Officers.

Candidates will be required to conform to the conditions defined in the "Regulations of the Naval Dental Service" (except in so far as they relate to the Competitive Examination)—copies of which have already been forwarded for your information—and if accepted will be entered on probation for a period of six months. A Probationary Surgeon Lieutenant (D) will receive pay, etc., as for Surgeon Lieutenants (D) on entry, and at the expiration of six months will, if favourably reported on, be granted a commission as Surgeon Lieutenant (D) in the Royal Navy with seniority as from the date of entry, but should he for any reason be considered unsuitable, he will be required to withdraw at any time during the probationary period.—I am, Sir, Your obedient Servant,

(Signed) EDWARD L. Fletcher.
For Medical Director General.

The Dean,
Guy's Hospital Dental School,
S.E.1.

N.B.—Any Student desiring to be nominated for a Commission in the Royal Naval Dental Service should send in his name to the Dean. Copies of the *Regulations* referred to may be had on application to the Medical School Office.

Dressers on Duty in the Front Surgery.

The House Committee on the recommendation of the Medical Committee through the Staff and School Committee, gives notice that on and after October 16th next the duty of attendance in the Front Surgery will fall wholly upon the dressers attached to the Surgeon "Taking In," in accordance with former custom.

The rota of duty is as follows:—

Six dressers are attached to each Surgeon, divided into three pairs a, b, and c. During their Surgeon's "Taking In" week, one pair (a) the dressers for the week, will take alternately all the accident and urgent surgical cases admitted under their Surgeon, and will be on duty in the Surgery from 7 p.m. to 9.30 a.m. Another pair (b), who will be dressers for the week at the next Take-In, will be on duty in the Surgery from 9.30 a.m. to 1 p.m. The third pair (c), who were dressers for the week at the previous Take-In, will be on duty in the Surgery from 1 p.m. to 7 p.m.

In the event of there being more than six senior dressers the supernumerary dressers may be allotted for duty at hours to be determined by the House Surgeon for the week, or may act as reliefs to the dressers on duty.

No order for the admission of a patient may be given by a dresser.

The responsibility for seeing that the dressers attend in the Surgery for duty at their appointed times devolves upon the House Surgeon for the week, who is responsible for drawing up the rota and submitting it to the Superintendent.

HERBERT L. EASON,
October 14th, 1921. *Superintendent.*

Guy's Hospital Dental School.—Entrance Scholarship in Dental Prosthetics, September, 1921.—Mr. V. R. Estment, £30.

Messrs. E. and S. Livingstone beg to announce that they have now taken over the agency for Great Britain of the *American Medical Record.*

Guy's Re-union Dinner—Liverpool and District.

The above Dinner will be held at the North Western Hotel, Lime Street, Liverpool, on Wednesday, November 23, at 7.15 p.m. Price of Dinner (exclusive of Wine) 12s. 6d.

Will any Guy's man who wishes to be present please notify me as soon as possible?

HORACE MATHER.
73, Rodney Street, Liverpool. *Hon. Sec.*

Boat Club Dance.

The Boat Club Dance, as previously announced, will be held on Thursday next, November 3rd, at the *Wharncliffe Rooms. It is hoped* that the dance this year will be even more of a success than that of last year, and that all who can will make an effort to be present.

There are only a few days left and as the number may be limited, applications for tickets should be *made as soon as possible to* Messrs. M. E. Shaw, R. F. H. Duncan, R. S. Chambers, A. Tom, C. H. C. Toussaint, or to G. C. Hughes, Hon. Sec, Dance Sub-Committee.

Football.

RUGBY.

GUY'S "A" v. HARLEQUIN'S "A."

Until the Friday evening before this match there was a doubt as to whether it would be played. Hence little advertising of the event could be done and but few spectators turned up for the opening match of the season at Honor Oak Park. Those that came along saw a very excellent display. The ground was very hard and this, combined with a high temperature, made the conditions very trying. Nevertheless, both sides played a very creditable game.

The Hospital won by a healthy margin, 2 goals and 6 tries (28 points) to 1 goal (5 points). The threequarters were in very good form, Van Heerden especially, but he gave his passes awkwardly. Weinburg was not so much in the picture, and neither Williams nor James had many chances. Sprong was in splendid form, and Aung was also very neat, some of his passes to Sprong being cleverly made. So at half back we had a big pull.

Van Niekerk fielded and kicked with the usual skill. Of the forwards Watson and Harvey were most prominent, but all the pack were great triers and it is scarcely fair to mention any as worthy of extra distinction. Sprong opened the scoring about 10 minutes after play had commenced, with a try in the corner. The 'Quin's had a good attacking quartette who ran and passed prettily, and soon Bloxam intercepted in our "25" and ran right away scoring by the posts for Price to goal easily. Before half-time Hutchinson, Sprong and Watson scored. Watson led up to Sprong's try, picking up well and passing judiciously. One try was converted, hence at half-time we led by 14 points to 5 points.

The Harlequin's were one short all the second half. The Guy's men lasted much better; Sprong

added two more tries, and Van Heerden and Harvey one each, one being converted. The final score was as above. The goal kicking was exceedingly feeble. Means will doubtless be found to improve this.

Guy's Team.—J. Van Niekerk, R. James, L. Weinberg, H. Van Heerden, H. K. Williams, E. L. Sprong, A. T. Aung, L. K. Watson, H. G. Close, G. H. Harvey, H. Hutchinson, N. Schabort, J. M. Morrison, S. P. Jacobson, C. Ive.

GUY'S v. GLOUCESTER.

A beating, 13 points to nil, against a team like Gloucester, who are always a very powerful team, scarcely seems disgraceful, especially on their own ground and before their own supporters. A pack that contains S. Smart, G. Holford, A. Hall, T. Voyce and F. Ayliffe wants holding.

Graham-Davies was ill and could not make the journey and Shelswell—sad to relate—was not very fit. C. L. Steyn and P. K. Albertijn were in the team for the first time this season. Van Schalkwijk joined these two and Hirschberg in the threequarter line, so that one could scarcely expect a great deal of cohesion all at once, with an unusual line, and with the opposing forwards tearing down on them with the greatest energy and pace. Play had not long been in progress before Brown sent Voyce over our line and Millington scored a goal. Dix was a little fortunate with an unconverted try and then misfielding on the part of the Hospital let in Daniell, whose try Millington again converted. All this scoring took place before the interval, and though we tried manfully all the second half we could not reduce the lead. The Gloucester team were too strong for us. Our backs were not together, but the forwards were very good indeed, W. H. Taylor had a good afternoon, and Duncan's form was very noticeable. Zondagh is developing into a useful man. Final score—Gloucester 2 goals 1 try (13 points), Guy's Nil.

Guy's Team.—J. K. Van Niekerk, C. L. Steyn, P. K. Albertijn, J. G. Van Schalkwijk, A. Hirschberg, F. Bekker, E. L. Sprong, W. D. Doherty, R. F. H. Duncan, E. E. Neser, W. H. Taylor, A. H. Shelswell, F. J. Biddle, G. Zondagh, R. H. Fouracre.

Congratulations to R. F. H. Duncan on playing so well in the First Welsh International Trial. One most sincerely hopes Duncan may bring honour to his Hospital and himself by landing a Welsh Cap.

GUY'S v. BRISTOL.

The Bristol team's Char-a-banc, or rather its driver, took the wrong turning, and play was therefore commenced late. We were against wind and sun and there was (please note this) a lot of wind. The game for a long time was scrappy because the balls were new, the ground hard, and the wind high. The players, keen in the extreme, could scarcely avoid making the play piecemeal. To play in a combined manner was difficult. We were not so well together at first and could not prevent Bristol attacking. Van Schalkwijk, at full back, was very good, and his kicking splendid. Many penalties went to both sides, and from one R. C. W. Pickles landed a good goal. Nothing else was scored during the first half.

After ends were changed, Guy's set up a very hot attack, but passing was difficult. Graham-Davies was good and so was Taylor among the forwards. Doherty lead his men with much enthusiasm. A good piece of work by Davies led up to Bekker's try, a typical dive for the line round the blind side of a scrum. Neser kicked a fine goal, and later was successful with a penalty. The passing on both sides never reached a very high standard, but the tackling did; it was most severe and thorough. Sprong did very well and Bekker worked in the most unceasing fashion. The team will settle down into a real good side with practice. The Bristol men were very fast in the loose rushes, in following up and dribbling, but their regular halves were away and this, doubtless handicapped the quartette behind. R. C. W. Pickles, who played for the British Army, played at half-back, and L. J. Corbett was at centre. J. S. Tucker, the well known forward, was watched with interest and he played well. Result, Guy's 2 goals (1 penalty), 8 points; Bristol 1 penalty, 3 points.

Guy's Team.—J. G. Van Schalkwijk, C. L. Steyn, P. K. Albertijn, H. Graham-Davies, A. Hirschberg, F. Bekker, E. L. Sprong, W. D. Doherty, R. F. H. Duncan, W. H. Taylor, E. E. Neser, E. H. Fouracre, G. Zondagh, L. K. Watson, F. J. Biddle.

ASSOCIATION.

GUYS "A" v. OLD CITIZENS "A."

This match was played at Honor Oak Park on October 8th, 1921, and was the "A" team's first match. The team suffered owing to the claims of the First XI. Willis turned out to take the place of a player who failed to arrive to time. It is essential that all selected should be on the ground changed ready to start at the time given on the notices. For home matches timed to start at 2.30, the 2.15 train from London Bridge is useless.

The "A" showed great keenness and were too good for their opponents. Caldwell scored from a corner in the first half; while after the interval further goals were scored by James (2) and Crisp.

The forwards were inclined to roam aimlessly about. Crisp led the line well, and Wayman especially in the second half, made some good centres from the left.

The halves were the outstanding feature of the team; Sennitt being the best of a good trio, all of whom tackled fearlessly and kicked well.

The backs played well together with the result that Wooldridge was seldom called upon.

Guy's Team.—T. Wooldridge, Walters, O'Rafferty, J. Palfry, S. E. Sennitt, Parry, L. C. Willis, James, B. Crisp, W. A. Caldwell and H. Wayman.

Guy's Hospital Nurses' Swimming Club.

The Nurses' Annual Swimming Gala was held on Wednesday evening, October 12th, in the Hospital Baths. There was a large number of entries and a most enthusiastic crowd of spectators.

A Jazz Band composed of Nurses in fancy dress added to the gaiety of the evening by playing popular selections, and the same nurses were responsible for the very attractive decoration of the Baths.

Lady Fripp, who came to give away the prizes, was presented with a bouquet of chrysanthemums, carnations and roses, by Nurse Pickard, the Nurses' Representative. Miss Daly of the Bath Club, and Sister MacManus acted as judges, whilst Mr. Jarman competed with the Jazz Band, and started the races.

The most interesting item on the Programme was a competition for the very handsome Silver Challenge Cup, presented by Lady Fripp for swimming, style and diving. Eight nurses entered for this, and they were marked on diving, breast stroke, motionless floating, and side stroke. As this was an unexpected item, and the nurses had a lengthy programme to get through, the standard was not so high as it might have been.

Results:—

Lady Fripp's Challenge Cup.—1. Nurse Garland, marks 41/70; 2. Nurse Cornwall, marks 36/70.

The Plunge.—1. Nurse Garland; 2. Nurse Pickard.

The Obstacle Race.—Nurse A. E. Young.

Two Lengths Flat Race.—1. Nurse Pickard, Nurse Sheppard.

One Length Flat Race.—Nurse Coles.

Diving.—Nurse Garland.

Back Race.—Nurse Garland.

Fancy Dress Race (Best Dress).—Nurse Sheppard and Nurse Banks.

The Team Race.—1. Nurses Garland, Murray, Cornwall.

Candle Race.—Nurse Cornwall.

In the Obstacle Race the competitors had to swim one length holding an open umbrella, and passing under a cord stretched across the bath; on the return journey, they had to take a baby's comforter from a string with their mouths; most of the competitors were disqualified.

At the close of the evening, the Cup and Prizes were presented by Lady Fripp. The Matron, who had most generously given all the prizes, thanked Lady Fripp and Miss Daly for coming down to the Gala, and thanked Lady Fripp especially for the Cup, which is to remain the property of the Nurses' Swimming Club. Lady Fripp responded, and added that she wished the Cup to be competed for each year. She made the condition, however, that only those nurses who gained 70 per cent. marks should have their names engraved upon it, thus hoping to raise the nurses' standard of swimming. Miss Daly said a few words about correct style, and most kindly expressed her willingness to come and give the Club a lesson.

Cheers were then given for Lady Fripp and the Matron.

Coffee was provided by the Home Sister for the visitors before they left.

Water Polo.

University of London Cup Final.

GUY'S v. UNIVERSITY COLLEGE.

The University Water Polo Cup Final took place at Pitfield Street Baths, on October 19th. Mr. Woodley, of the M.W.P.A., kindly gave his services as referee.

The fact that Hutchinson and Cohen, one suffering from septicæmia and the other barely recovered from rheumatic fever, both insisted on playing undoubtedly gave us the game.

Guy's started well and, after a movement led by Painter, were soon shooting hard at goal. Simons scored first with an excellent shot. University College then scored in quick succession three goals, all of which originated from Fisher, their centre-half. Throughout the remainder of the game, however, Fisher, who had just returned from a tour with a representative English team in Belgium, was very efficiently marked by Painter.. Hutchinson provided a little light entertainment by becoming entangled in his own knee bandage.

Guy's entirely dominated the game in the second half. Able work by the defence and good combination lead to three goals from Hutchinson and two from Cohen. Harvey also scored after a short dash with three opponents on his heels. Another goal from Fisher left Guy's winning 7—4 when time was blown.

Guy's Team.—F. A. Sampson, H. W. Harvey, C. A. Wakeford, O. F. Painter, G. Cohen, F. G. Hutchinson, J. Simons.

The Water Polo Team can congratulate itself on an excellent season, and particularly on winning the Inter-Hospital and University Challenge Cups.

All those interested in Swimming and Water Polo are asked to get into touch with the Committee as attempts are being made to continue swimming practices throughout the Winter.

"Guy's" with the Gloves.

By J. W. BUTLER.

Member of the N.S.C. and well-known Boxing Critic.

The alluring magnificence of the Royal Albert Hall possesses a gorgeous setting for sport, especially that of boxing, but I have witnessed both fights and fiascoes there.

In the ring of the National Sporting Club, the Mecca of British boxing, one sits in comfort among the aristocrats of the "noble art," but the bouts are not always interesting or entertaining. After the Ted Lewis v. Johnny Basham pugilistic panorama, I had a poor night's sport at the N.S.C. watching a Welshman named Colcombe, from Jimmy Wilde's village, show us anything but good boxing against a seasoned boxer named Kid Davis, and then came a tonic at the gymnasium in Maze Pond. It was a pleasant change to see unadulterated sport, and boxing above the ordinary. G. L. Lloyd Williams is undoubtedly a fellow countryman of Wilde and Basham, and he and J. L. L. Walker fought a clever contest. It was the bout of the evening, full of skill, earnestness and courage. Williams won because he understood better the value of a straight left, but Walker is also a boxer of promise. Williams, like Basham, is a Welter.

Another pair of welters, J. D. O'Rafferty, and J. S. Du Toit did not have "welcome" on the mat. They fought like bear cats, and the Irishman possesses a right swing which when it connects on a vital spot has the same effect as an anæsthetic. Rafferty won a smelling rather than a scientific contest.

J. D. S. Thomas has a picnic with C. S. Gross in the featherweight event. The latter is plucky enough, but that asset alone will not win boxing matches. Thomas is a stylist. His judgment of distance is perfect, and so is his hitting. I would like to see him opposed to one of our leading professionals. The student would give the professor something to think about. C. D. A. James and G. A. Martin had a fight. James was handicapped for size, but he belted his opponent good and strong. Erratic leading and a fondness for affectionate embraces brought him under the censure of the High Judge, Alf. Hewitt. An extra round was ordered; James was slow to lead and Martin just scrambled home. Still, one cannot hold inquests on youngsters. They'll learn.

Naturally, interest is keen upon the candidates for boxing honours against Oxford University, and in the bantam division, S. P. Meacock will represent Guy's Hospital, J. D. S: Thomas the feathers, N. M. Holloway the light heavyweights, and W. H. Summerskill the heavies. The latter's name should be an invaluable asset.

I must congratulate Mr. N. L. Lloyd, the Hon. Sec., who officiated as M.C. His "Professional" manner will be a great advantage for patients in future. The Instructor, Prof. Alf. Hewitt, needs no thanks. The aptness of pupils is sufficient praise.

Pointing the Obvious.

A thirty-second year man writes pointing out the strange freaks of the anatomical mind, but is the anatomist the only one whose mind works in such a manner? I find the following from a standard book on surgery:—

"When a patient has sustained a stab, a gun shot, or other deep penetrating wound in the right hypochondriac or epigastric regions and this wound leads inwards towards the liver, an injury to the liver can be diagnosed with certainty."

It is pleasant to be certain of something—even the obvious.

Specialities.

ZOMOGEN FOOD PRODUCTS, LTD., 63, York Place, Edinburgh.

Zomogen is put forward as a new Tonic Food of high nutritive value containing Hæmoglobin, Lecithin, Cholesterine, Potassium Salts, Phosphates, Proteids, and Vitamins.

It is a thoroughly British Preparation, carefully prepared after extensive tests, by highly qualified experts.

This Food is made in a form both pleasant and palatable.

It is easily assimilated and should be valuable in all cases of Anæmia.

The Zomogen Products Co. are anxious that the efficacy of this Tonic Food should be thoroughly tested by Medical Men, and will welcome an opportunity of sending a supply gratis on application.

ED.—A. T. R.

GUY'S HOSPITAL GAZETTE.

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Passim.

THE War Memorial Committee have asked us to make a final appeal to our readers for help for the Memorial Fund. The Committee is in debt. The estimated cost of the Memorial Arch has been exceeded by £300, and the long promised Memorial Number of the Reports (which is now in the press ready for printing) has proved to be a most costly volume. Although money is still coming slowly to the Fund by subscriptions, which were promised in instalments, and which were to be spread over five years, the Hon. Treasurer sees little prospect of solvency for the Committee if £200 cannot quickly be raised. He does not ask for large sums. It is vain to ask, under the present financial conditions, for guineas, yet guineas are not needed: shillings are enough. If every man at the Hospital would give only, say, five shillings, the £200 would soon be raised.

"PLEASE can I have a ticket for the Tea Party?" This is the question which is now asked hundreds of times a week in the Surgery and in Out-Patients by eager, grimy Borough children. Most of them have memories of other happy Christmas afternoons in the Out-Patients Hall, and all of them hope to spend this Christmas with us. It will, of course, be impossible to give every suppliant one of the prized tickets, for not more than seven hundred children can be packed into Out-Patients, and cost of the treat for even this fraction of the multitude is no small sum.

Let us pause to explain to the uninitiated, who have not heard of the Landon Tea, what we are talking about. Several years ago a sum of money was left by Dr. Landon to provide a tea each year at Christmas for those children who had been patients or out-patients of the Hospital during the previous year. The interest on this sum, together with money collected each year in the Hospital enables us to feed and entertain seven hundred guests each Christmas. In the halcyon days before the war, the children, in addition to their tea, all received a toy, some fruit, some useful article—such as a pair of socks, a woollen muffler, or a handkerchief—and a gift of tea and sugar to take to those at home. During the war many of these gifts (especially of sugar and of fruit) had to be dispensed with, while the toys, being much dearer, could not be supplied as liberally as before.

Still the kiddies enjoy themselves just as much as they ever did. Last year there was a band there playing all the popular jazz tunes as loudly as it possibly could. But the choruses were sung with such a will that they easily drowned the accompaniment.

It is hoped that this year we shall be able if we have sufficient help to make the tea an even greater treat for the children. We therefore appeal to our readers to send gifts either in money or in kind for the tea. Gifts of dolls and other toys will be especially welcome, for toys are still dear and difficult to obtain, and the dolls one buys dressed—we are told—are never so acceptable as those which have been bought in negligée, and have been subsequently fitted out with a complete tailormade trousseau.

Although the cost of the tea comes each year to nearly £150, large gifts of money are not solicited. What we would like would be a subscription of half-a-crown from every man, whether in or out of the wards. Those who happen to be in Out-Patients on Christmas Day (or, rather, Boxing Day this year) when the Niggers arrive will count their money well spent. No prima donna, no great actor, no lion comique, ever got such a volume of full-throated and whole-hearted applause as that, that greets the President of the Residents each year as he leads his motley chorus down into Out-Patients (the Niggers go there nominally to lead the Kiddies in song, but there is rarely any doubt as to who is doing the leading).

So remember to send money, fruit, crackers, or dolls, and especially dolls, and if you can, come and see the fun which your bounty is helping to provide,—then you will give more next year.

Sister Out-Patients will be glad to receive all gifts, though no doubt most men at the Hospital will find it most convenient to pay up their money to the men, who are already wandering round the Wards, the School, and the College with little red books and fountain pens ready in their hands.

THERE have been a lot of rumours current during the last few weeks to the effect that the Christmas festivities at the Hospital were to be seriously curtailed this year. We are now able to state (unofficially) that the restrictions will not be as severe as was anticipated. It is proposed that one week only shall be devoted to merrymaking. The fun will commence on the Monday, which will be (although it is Boxing Day on the calender) our official Christmas Day. On this day the Christmas dinners will be served in the wards, the Niggers will go round, and the Out-patients will feast. The Tuesday, Wednesday, Thursday, and Friday will be devoted to Concerts, and on the Saturday—which is New Year's Eve—the Nurses' Dance will be held.

This programme seems to us almost ideal, and we hope that it will be found possible in future years to continue with this scheme of fitting in everything between Sunday and Sunday, even though it may involve holding some Concerts on the days before Christmas. Nothing will be lost by restricting Concerts to four days. In previous years when they dragged on for a whole week, we soon tired of listening in one ward, to the same old songs and gags which we had heard the day before in another part of the Hospital. No doubt, some difficulty will be experienced in avoiding the clashing of too many concerts on the one day. This could, however, be avoided if only several wards would combine to give a communal concert. Astley Cooper will not be able to entertain us on New Year's Eve, but there is no reason why their concert should not be held on the 30th, so that it may form the finale in the round of concerts. We feel sure, too, that the Nurses' Dance will provide an even more successful New Year's Eve than Astley Concert has been wont to. We shall certainly avoid that uncertain interval of waiting, shivering in the cold Colonnade, which always occurred between the end of the Concert and midnight.

THE new Clubs' Union Handbook has now been published, and may be obtained by all Clubs' Union members on application to the Medical School Office. It is this year a most interesting publication. It is far more than a book of reference, excellent though it is for this purpose; it is a memorial of the prowess of Guy's sportsmen in the last year's most successful season. We recommend all members of the Union to secure a copy at once, and we trust that next year's issue will be able to tell an equal tale of success.

WE are sad to learn of the death of Dr. Henry Horsley, who was one of the oldest, if not the oldest, of living Guy's men. Dr. Horsley, who qualified in 1859, lived to the age of 83, an age rarely achieved by a busy practitioner.

WE have received a circular from the British Lampblown Scientific Glassware Manufacturers' Association, in whose hands, it appears, the manufacture of clinical thermometers in this country is largely settled, asking for our support in passing a Bill through Parliament to make compulsory the testing of clinical thermometers by the National Physical Laboratory. Such a test was made compulsory during the latter part of the war by an Order in Council. When this lapsed an attempt was made (in July last) to pass a Bill to replace it, but objections were made by several Members, and the Bill had to be deferred until the coming session. All medical men realise the value of a reliable clinical thermometer and all will, we feel sure, join with us in hoping this Bill will soon become law. The figures quoted in the circular speak for themselves. When the test was first introduced it was found necessary to reject one thermometer in every four. The makers were stimulated by the stringency of the test to take greater care over the calibration of their instruments, so that in the end, before the abolition of the compulsory test, the rejections had dropped to one thermometer in seventy. If we have no protecting law the standard will soon regress to its old level.

The First Operation for Relapsing Appendicitis.

SIR ALFRED FRIPP in supporting a vote of thanks to the Chairman, Sir Charters Symonds, at the first meeting of the Physical Society, asked if it were not the case that the first operation undertaken for appendicitis in the relapsing stage had been performed by him and in Guy's. The chairman having only replied by a silent assent, we have thought it would interest Guy's men to learn something more of the matter. The following are extracts from the original paper and from the Historical Summary given by Howard Kelly, Gynæcologist at Johns Hopkins Hospital, Baltimore.

Howard Kelly, in his large work on "The Appendix and its Diseases" which opens with a complete history of the subject, thus writes of the operation for appendicitis in the relapsing form:—

> "Charters Symonds, an Englishman, did what is undoubtedly the first internal operation for appendicitis, making a lateral incision without opening the peritoneum." He goes on to quote from the paper in the Transactions of the Clinical Society, Vol. XVIII, which was read on May 9th, 1885. He gives many of the details, including the remark that the suggestion came from Dr. Mahomed, and gives in extenso Mr. Symonds's comments as to the part he took in the undertaking, as follows: "I believe I am correct in saying that this is the first case in which a concretion or calculus has been removed from the appendix vermiformis without at the same time opening an abscess, and the credit of whatever value rests in the procedure must be given to my lamented colleague, Dr. Mahomed, at whose suggestion the operation was undertaken, and who advocated the inguinal incision in opposition to that along the linea semilunaris proposed by myself."

Referring to the original account, it is interesting to note that the patient was admitted into Guy's on July 16th, 1883, under the care of Dr. Mahomed, and that the operation was performed on August 24th in the same year, and not in 1885, as stated by Howard Kelly. Dr. Mahomed died of typhoid in 1884.

The concretion which is calcareous will be found in our Museum, and a coloured illustration in the Clinical Societies' Transactions.

Correction.

DEAR S.R,—I shall be obliged if you will allow me to correct an error in my Clinical Lecture published in your last number. It was stated that foreign bodies more often pass into the left bronchus, this should read *right* bronchus,—Yours, etc.

23, Devonshire Place, W. M. MOLLISON.
Upper Wimpole St., W.1.

Sir Alfred Fripp's Address at the Opening Meeting of the Physical Society.

GENTLEMEN,—First, please, let me thank the Presidents of this ancient yet ever young Society for the honour they have done me in asking me to address you on the occasion of the opening of this new session. I fully realise that to follow Dr. Shaw's memorable address of last year and the other old teachers of yours who preceded him is at once a great honour and a difficult task.

I shall not attempt to vie with them, but shall content myself with a modest contribution to a topic which has of late made a welcome re-appearance in the columns of the Guy's Hospital GAZETTE.

You will all keep your GAZETTES, and you will find you value the bound volumes more and more as the years go by, both for practical and sentimental reasons. And you will be grateful to the Editor for having recorded the musings of several observers upon this subject—which is none other than "the art of life" or, rather, the art of a medical man's life.

Many years ago the apprenticeship period gave the embryo medico an opportunity of acquiring from his seniors the elements of his art, but that stage in his evolution has been squeezed out of the curriculum. The ever-increasing boundaries of our branches of science have forced the authorities to crowd the years he spends at his hospital with more and more examination subjects. Little appetite and less time is left for him to devote to considerations the importance of which will only be fully realised when he has left. Then, qualified in the sciences and with more or less experience of hospital practice, he goes forth into the great world unversed in knowledge of arts, perhaps without having even considered or even been informed that his profession is called the Science and Art of Medicine. He may well wish he had behind him some of that experience which all seniors have gleaned in the course of laborious years.

The next best to knowing a thing is to know where to go to find it. He will find this subject discussed in the GAZETTES of 1921.

Now it is obvious at the outset that each Senior who attempts to contribute to this subject must recognise that no two individuals have exactly the same experiences. And such as do have approximately the same experiences will attach very different values to them—will view them differently—will draw different inferences from them. Temperament will colour his impressions—in some the heart more often over-rules the head than in the opinion of others it should—and vice versa! No man is perfect. Trees do not grow to the sky—we are only human after all. We all have the defects of our qualities. It is impossible to know what others will think of our efforts. To be sure is impossible, to feel sure is dull, to seem sure is arrogant.

About tastes and temperament it is useless to argue, and therefore it is with considerable deference in the presence of some who are senior even to me that I attempt to chat openly to this coterie of young friends about some of those matters which seem to me essential to the study of that greatest of all arts, namely, the Art of Life.

It may seem strange, but I believe it is right to call that the greatest of all arts; certainly it is the most indispensable, and it is probably the most neglected.

It is not many years since it was customary for almost every English-speaking medical school to open each winter session with an introductory address from one of the Seniors, and a vast number of these addresses were devoted to an attempt to contribute to our subject of to-night. You cannot read them all. But if you want to read a few real good ones, start with Osler, Moxon and Paget—all of which you can get in our Wills' Library.

These and other great minds have put the best thoughts into the best words. There is probably nothing new to be said—certainly I have no hope or intention of trying to say anything new to-night.

So you begin to see the object I have in view. It is to help you in however small a way to surmount some of the many difficulties which beset the path you have chosen. To help you to become happy and successful in that state of life to which you have been called. To present for your consideration some of the gleanings of the past 30 odd years: You remember the saying—If only the young man knew or the old man could. Well, I am the

old man trying to help the young man to see life clearly and to see it whole. To prevent him being too easy a prey to outrageous fortune.

I may not succeed, but as Gilbert says—and it is a real joy to know that your generation appreciates the great qualities of his work and Sullivan's as much as mine did and does—"A man might try."

Well, you have chosen by far the finest of all the callings in the world to-day, provided you have felt called to medicine, provided, that is, that you have come of your own free will and feel that you really love it. If you have been forced into it, if you do not love it, if your greatest hope is to get rich quick, you will find it a rotten profession and the sooner you get out of it and start again at something else the better, for you will not be happy in it and you will not be a success if you keep your eyes fixed on money.

For it is a bad gamble—you will find sharks in all sorts of disguises, in all walks of life as surely as you will find gentlemen in all classes of society.

And it is hard work. I often doubt whether anybody outside our profession realises how hard, how continuous, how exacting, how responsible; for all the time we are dealing with questions which are essential to the welfare of others and very often with matters of life and death importance. Every successful practitioner finds he has too much to do; if he takes hold of his job at the right end he will realise the truth of the saying that there's no fun like work. Nothing succeeds like success. If he has not enough demand for his services he may take it that he is not being successful, and he had better at once start investigating why he is not more wanted. He will almost certainly find that it is some defect in his conduct. Somebody well said that that conduct constitutes three-quarters of life.

Probably you realise already that there are some things in life which are beyond all money, and the love of home, of children, of country, and all the humanities and ideals and all faith, whatever your faith, are others; and all of these loves have free play and great power for good in our profession, opportunities for helping—helping lame dogs over styles—abound, and you grasp them without thought of immediate reward.

There are many pitfalls—things are not always what they seem. A man may be rich although he wears a big diamond ring.

So it is not an easy profession to be either successful or happy in. Our subject groups itself round these two words.

And you are joining this finest of all professions, and you are joining it at a wonderfully interesting epoch in its development. Just think what advances have been effected by its self-denying efforts during the past 30, 40, 50 years! Anæsthetics, antiseptics, bacteriology, radium, X-rays, suggestion, the study of the ductless glands—to mention only a few—and all the practice which depends upon their application, what a veritable Renaissance—as striking and as enduring as the Renaissance of Art in the Middle Ages.

I called it self-denying, because you will not find that any of the great contributors to this advance "got anything out of it," as they say, because not a few have sacrificed their lives in their effort to help humanity, and also because the constant endeavour of our branch of Science has been to cut away the ground from under our own feet—to curtail the need for doctors.

This is an instance of altruism we may surely all be proud of—it is so different from the view expressed by the ignorant and unsympathetic members who abound in all classes of the public. You can generally spot these folk by the aggressive allusions they make to "professional etiquette."

There is a rule of the road in medical practice, and it is safer to observe the rules of the road. Now it is quite easy, though in their presence it is seldom worth while, to show that the rules, or tenets (for the code is mostly unwritten), of professional conduct have been framed for the welfare of the public. Thus, in any and every case the interests of the patient must always be the first and the chief consideration of the doctor. If it is not opposed to the welfare of the patient you must next consider the interests of the profession, and not until these have been satisfied may you, in the third place, consider your own interests. But I digress—this is another story—a very large and important one—but let me return.

What advances have been made in my time! And what advances will be made in the next 30, 40, 50 years that are yours! What an in-

teresting time you will have! Surely for one thing no operating theatre will be complete without an equipment of "surgical spare parts" in bottles on the shelf—kidneys, brains, liver, blood vessels, and mucous-lined viscera—and a host of other things ready for grafting, in addition to the ovaries, bones and joints which have already been implanted successfully. The catalogue of "spare parts" will, perhaps, be as long as the latest lists of organotherapeutic products issued by the enterprising firms which fatten on their sale to-day.

Let us consider the prospects of each individual who comes into this profession at this interesting epoch in its history, and how he may improve those prospects. Incidentally it is obvious that he starts his battle of life with the whole world in a condition of unrest consequent upon the war. There seem to be fresh values for everything, social, political, economic and even moral. One of the bye-products of this world condition seems to be a curious new relationship between the public and the doctors.

Next let him ponder the fact that in any profession, just as in commerce, it is one thing to have goods to sell and quite another to persuade the public to come and trade with you. You will leave the Hospital endowed with certain wares which you want to market, and since you have acquired these wares at Guy's you will find that the stock is better than that owned by most of your rivals. Their acquisition has cost you much time and money and now you have got to persuade the public in the market to trade with you.

So, to put the same thing in other words, remember that throughout life just as in examinations—and by-the-by the candidate often forgets this point in examinations—marks are allotted for manner as well as matter. We all know instances of men getting spun at examinations when we who have the best experience of their qualities are sure they knew enough to get through easily. The trouble is, as Smee said of the crocodile, "He knows, but he cannot say." The same lack of ability to bring his goods to market probably explains the tragedy of J. K. S.'s

"Grave grey lawyer in King's Bench Walk
Whose clients are passing few;
He seldom speaks in these lonely weeks,
What on earth does he find to do?
Well! he stroked the Eight! What a brilliant fate!
And the Newcastle barely missed
A future Lord Chancellor—so we'd thought
In the days of the old school list!"

A man who would win success must bear these and other facts in mind and he will find that it is man's work, not boy's, to carve his name among the successful ones of life.

The first question each one of you has to consider after recognising these elementary facts is, what pond does he elect to swim in? Where does he choose to put up his plate? Or, in other words what public does he choose to cater for? Does he elect to go into general practice, or some speciality? Does he wish to work in the town or country? In a large town or a small one? It is one of his last free decisions, so let him ponder it well, let him begin to study it early—the answer is well nigh irrevocable.

Some are fascinated by the laboratory life, but only if they are endowed with abundant private means can even they afford to ignore the opinion of their particular public, and the only piece of advice I will venture as specially appropriate to this class—though useful to be remembered by us all—is what I was told one great scientist at least had the forethought and the courage to have written up round his laboratory, "Take care lest you find what you seek." If this injunction had always been observed perhaps we should have seen fewer fads ridden to excess. Of course, I do not mean to infer that any of you would repeat that mistake, and yet it has been repeated so often and so recently and the ill-effects have often gone so far that the age-old adage will evidently bear recalling to our minds to-day. Let us be warned by such happenings in the recent past and by the sport which publicists like G. B. Shaw make of them, to the detriment of the standing and proper influence of our noble profession. It cannot do much good to our reputation in the public estimation to hear a consultation nick-named a conspiracy. Let us be careful that in future such mud-throwing is not justified, even when the thrower claims the license of a clown.

The repetition of premature publication would be shunned by all who claim to be true scientists. For science means knowledge, and not guessing, and when guessing and attractive jargon are used as a basis for money making it becomes very reprehensible, and people

whose pseudo-scientific publications and whose conduct conduce to such practices are real danger spots to our profession, especially when they bear names which exercise prestige suggestion over the unthinking public. You see there is always a section of the public who are on the look-out for new fads. They like the *dernier cri*, and they are the makers and very soon the breakers of the latest wonder-doctor of society.

They are the ready prey of any charlatanism so long as they can think it is new. They are the same class as is always on the look-out for a new sensation—or a new dish—it has been said that the restaurant cook who could invent a new dish would be a millionaire to-morrow.

They roll the newest catchwords round their tongue with as much self-satisfied unctuousness as our fathers did the words neuritis, diathesis, adhesions and other shibboleths which really we have seldom any accurate appreciation of—airy vapourings, fashionable obscurantist jargon.

Enough said—I will not risk libel; but think it out, and there will come into your head as appropriate the old thought that our little systems have their day and cease to be.

Some will go into one of the Services with its assured pay and pension, the majority will go into some form of private practice. To every one of you wherever your choice falls I would say—Cling to your health as long as you can. Every man to keep healthy needs—as it has been put—a horse and a hobby-horse. He needs exercise and he needs a hobby to take him out of his work. He should become a connoiseur in something—even if it is only in beetles' wings.

Every artist recognises the necessity of occasionally standing back from his easel. Our profession affords a wonderful training for watching and assessing the value of details. Every man should acquire the art of switching himself off and relaxing his attention.

Then do not be afraid to make honest mistakes. It has been well said that the man who makes no mistakes makes nothing, but the man who succeeds is he who repeats the fewest mistakes.

> "Every failure is a step advaneed,
> To him who will consider how it chanced."

Let no experience be utterly forgotten, rather try to let yourself become part of all that you have met. I am a firm believer in the continued value of remembering the good thing one comes across—wherever one comes across it. I wish one could always remember the attribution of all the good sayings one has come across.

Do not mind admitting that you "do not know," even in examinations. It is striking how much you will be forgiven for not knowing, and how soon you will be pilled if you guess. For the guesser in our profession is a real danger to his patients, perhaps a greater danger than the symptoms which made them come to him; and the fool in our profession is the man who does not know what he does not know.

Do you remember that old Arabian jingle which runs—

> "He who knows and knows he knows,
> He is wise—follow him.
> He who knows and knows not he knows,
> He is asleep—wake him.
> He who knows not and knows not he knows not,
> He is a fool—shun him.
> He who knows not and knows he knows not,
> He is a child—teach him.

(To be continued.)

Papers by Guy's Men.

Sir W. Arbuthnot Lane, Bart., M.S. The Changes in the Skin in Chronic Intestinal Stasis.—*Medical Press and Circ.*, October 26th, 1921, p. 336.

F. D. Saner, F.R.C.S. Some Aspects of the Treatment of Acute Suppuration.—*Lancet*. October 30th, 1921, p. 891.

——. Three Cases of Fracture of the Scaphoid Bone (wrist).—*Practitioner*, November, 1921, p. 367.

N. Mutch, M.A., M.D., F.R.C.P. The Treatment of Cardiospasm (illustrated).—*Ibid.*, p. 339.

E. G. Slesinger, O.B.E., M.S., F.R.C.S. Non-thyrotoxic Goitre.—*Ibid.*, p. 355.

F. Bocquet Bull, L.R.C.P., M.R.C.S., L.D.S. An Interesting Case in Practice.—*Brit. Dent. Jour.*, xlii., 1921, p. 993.

Honours.

The King has given permission to several medical men to wear the Cross of Chevalier of the Legion of Honour, conferred by the President of the French Republic in recognition of valuable services rendered during the war. Included in the list is Sir W. Arbuthnot Lane, Bart., C.B.

Royal Society of Medicine: Section of Odontology.

PRESIDENTIAL ADDRESS BY MONTAGU F. HOPSON, October 24th, 1921.

Ladies and Gentlemen,—

It is of interest to note that just fifty years ago a paper, entitled "On the Position of Dental Surgery as a Profession," was read by Charles James Fox before the Odontological Society of Great Britain. As might have been expected from one who bore a name famous in a great period of political history in the Eighteenth Century it dealt with Reform and Reconstruction. It was a paper of some length, and coming late in the evening's proceedings the discussion thereon was adjourned until the next meeting.

In the interval the Council met and decided that matters of a political nature were outside the orbit and not in the interests of the Society. As one who knows something of the inside of professional politics I am certain that the decision arrived at by the Council and endorsed by the members was altogether wise, for was it not Huxley who said that he was inclined to believe that the practice of the methods of political leaders destroyed their intellects for all serious purposes. So this Section, following the example of its parent has eschewed the precarious paths of politics and devoted its efforts to the advancement of the science and practice of Dental Surgery.

From the earliest times the practice of a speciality has been derided by critics and afforded material for the jests of humorists. Thus in the Greek Anthology we find more than one epigram relating to specialism—

"If you have an enemy Dionysius, call not down upon him Isis nor Harpocrates, nor whatever god strikes men blind, but Simon (*the oculist*); and you will know what God and what Simon can do."

Again, "Agelaus killed Acestorides while operating; for, 'Poor man,' he said, 'he would have been lame for life.'"

In days gone by the sum of knowledge of disease was within the appraisement of an individual, hence he who set out to treat one particular malady was not infrequently an empiric and a charlatan. To-day no one can aspire to the possession of all that is known concerning the causation, prevention and treatment of disease. The field presented by the practice of medicine has become so large that a division of labour is inevitable. Hence, there never was an age in which specialism has been more rife, never an age in which specialism has reached such a high degree of perfection.

But concurrently with the increase in general knowledge there arises a demand for the wider and ever wider enlightenment on the part of the specialist. He needs more and more to be on his guard against the dangers which so easily accrue from constant concentration on a limited arena; the tendency to regard a particular part as a separate entity instead of a portion of a greater whole. In short, the best specialist is he who in the truest sense of the word is the best pluralist, and I venture to assert that in no branch of the art of healing is there a greater need for this wider knowledge than in the practice of dentistry.

The field in which we labour may be small, but it has no boundaries. It is neither self-contained nor self-supporting. Its soil is irrigated by streams rising in adjoining territories, bearers of fertilizing agents of many kinds manufactured in various localities. These streams may be vitiated or contaminated ere they arrive, or they may pick up in our field poisonous products to be deposited in the beds of streams flowing through other districts. It becomes the duty of a specialist, then, to maintain the health of his particular province, in order that it may play with perfect smoothness its allotted part in the bodily machine. But it is clear that he in turn is dependent upon the efficient working of all associated parts, hence the need for intelligent co-operation, for no amount of mere technical skill can prevail without knowledge of the broad foundations of anatomy, physiology and pathology and the general processes of disease.

Surely it is in this matter of co-operation that the justification of the existence of this great Society is to be found, each Section being leavened, corrected and inspired by the activities of the others.

There are, however, particulars in which the practice of Dental Surgery differs from that of other specialities. You are perfectly familiar with them, and I mention them here because our critics are prone to forget them or, perhaps, do not realise them. The organs

with which we are chiefly concerned present certain peculiarities which mark them off from other bodily tissues. Enamel and dentine when injured or lost by accident or disease are not replaced and restored by nature, nor are plastic operations, in the surgical sense, possible on these tissues. Further, the main nutrient supply of a tooth is so situated and distributed as to render it especially vulnerable, a comparatively trivial injury leading to its destruction. Hence the dental surgeon is called upon to restore lost tissues with foreign materials and to replace in their entirety organs and parts which have been lost. Such operations demand a high and special technique and a knowledge of materials not required by other surgical specialists.

Yet the dental surgeon is dealing all the time with living tissue, the pathology of which differs from that of other tissues only in that it is modified by the pecularities of the structure and the relations of the parts concerned.

No one, I think, will deny that we have passed through a phase in which both operative and mechanical technique over-reached itself and was carried to an unjustifiable extreme. Just as there are persons of the so-called artistic temperament who possess the temperament without the art, so we, for the moment, forgot that pure science must always precede applied science. With his usual caution, however, sometimes decried as lack of initiative, the British practitioner was slow to emulate the vaunted mechanical triumphs of his colleagues elsewhere and was the first to realise the defects and to abandon the methods.

But because for the moment we have to cry a halt, and admit defeat and acknowledge our errors in the steps taken to make large restorations of lost dental tissues, in the methods of replacing individual teeth by so-called fixed and removable bridges, and reconsider our position in regard to pulpless teeth, the more urgent becomes the necessity for further experimental research based upon accurate scientific data, in order that the satisfaction derived from the refutation of old errors may be excelled by the joys pertaining to the discovery of new truths.

Formerly the proceedings of the Section and of the Society which preceded it were enriched by casual communications, and papers on matters of practical import. Of late they seem to have become the exception rather than the rule. I think this is a distinct loss, for surely such communications are of real value and should not be considered beneath the dignity of the Section.

I am glad, therefore, that at this first meeting of the Session we are to have a paper by Mr. Parfitt on the vexed question of "The treatment of Pulpless Teeth." Later we have been promised papers by Mr. Douglas Gabell and Mr. Frank Coleman, one dealing with a subtle point in Dental Mechanics and the other with the Surgery of Extractions. Then in February we propose to devote an evening to the exhibition of Clinical Cases, and I would ask you now to make a note of that date and to help us in making the meeting a success by collecting and bringing forward interesting cases under your care. There is also another branch of Dental Surgery which has been somewhat neglected by the Section in recent years, a neglect partly due to the fact that the Study and Practice of Orthodontics has proved to be sufficiently important to absorb the attention of a special society. Is it too much to ask some of our members to treat us to the crumbs which fall from their rich table when they dine elsewhere?

Whilst the majority of us are, and must continue to be, fully occupied in wrestling with the ravages of manifest disease, there remains the more important problem of its prevention. Take the two most prevalent and far-reaching dental diseases of to-day, caries and "pyorrhœa." It is quite a common thing to hear them spoken of as preventible. I frankly admit that, after a long experience which, I trust, has not been wholly wasted, I am neither satisfied by the generally accepted explanation of their ætiology, nor am I able completely to control their occurrence. To attribute the incidence of caries entirely to local, environmental and external causes, and to exclude, as is so often done, general factors, metabolic and pathologic, is surely to claim for dental tissues a wider difference from the other tissues of the body than our present knowledge warrants.

We know that many people remain immune, that in others the disease is localised to certain teeth, or to particular surfaces of individual teeth, and not necessarily to those surfaces which afford ready stagnation areas. We observe that subsistence on a diet largely carbohydrate in character does not invariably lead

to the appearance of caries. Where, then, and of what nature is this immunity factor, or factors? Does it reside in the quality of the tooth tissues, and are they once laid down immutable? Do they undergo changes which render them more vulnerable or less vulnerable as the case may be? Or is the factor to be found in the character and variations of the constitution of the oral secretions? Does it really follow that—

"A little soup; and fish or meat;
A scrap of cheese; a modest sweet;
Fresh fruit; a draught of water (neat);
Will keep us out of Harley Street." ?

We are all witnesses of the far-reaching and evil results of oral sepsis. We are agreed as to the local conditions which appear to act as predisposing causes. But who can say why it is that, given one or more of these recognised predisposing conditions, chronic suppurative periodontitis does not always supervene, or explain why it is that it occurs when they are apparently absent? Again I ask, wherein lies the immunity factor?

Here are problems awaiting solution. Modern science has accomplished much, but the processes of disease are not so simple as text-books lead us to imagine; they are exceedingly complex, and it is no easy matter to discover the laws which govern them. May I remind you of the oft-quoted words which Plato put into the mouth of Socrates—

"I dare say that you have heard eminent physicians say to a patient who comes to them with bad eyes, that they cannot cure the eyes by themselves, but that if his eyes are to be cured, his head must be treated; and then again they say that to think of curing the head alone and not the rest of the body also, is the height of folly. And arguing in this way they apply their methods to the whole body, and try and treat and heal the whole and the part together. Did you ever observe that this is what they say?"

Hence we welcome the recently appointed Dental Research Committee under the Medical Research Council, for it is only by combined, co-operative, and co-ordinated work, carried out under expert advice and supervision that these problems will be solved. That they will be solved mainly in the Laboratory I doubt not, but carefully recorded clinical observation will play a part. Here, then, will be work for the observant general dental practitioner. A line of research which can be conducted *pari passu* with his daily work; an added interest, a relief it may be from tyrannising routine. Next month Mr. F. W. Broderick will bring before us the further results of his continued investigations of the Relation of the Endocrine Secretions and Dental Disease. Later in the Session Mr. Livingston of Liverpool will contribute a paper on The Experimental Production of Rheumatoid Arthritis, and Mr. Malleson one on General Histology.

But apart from the advancement of Science and the dissemination of medical knowledge, this Society serves another purpose and one to which I am indebted beyond my powers to repay: the promotion of those qualities of fraternity, goodwill and toleration, which are summed up in the word Charity.

Our's is an exacting and exhausting calling. At the end of a strenuous day the attraction of an easy chair at home is difficult to resist; the man, however, who is content with reading the "Proceedings" and never attends a meeting, is getting but half the value he might obtain from his membership. He is missing one of the things that he most needs, direct contact with his brother practitioners. To hear a man speak his words, personally to discuss an obscure point with him, is far more enlightening than merely reading his paper in cold print. Those little chats before and after a meeting are the surest prevention of that egoism and narrow-mindedness which isolation so easily engenders as the years slip by. Indeed, they do more, they help us to *know* one another and foster that true professional spirit which thinks no evil. Of course there are some men so constituted as to be unapproachable. You remember in Stevenson's unfinished romance, "Weir of Hermiston"; someone says to Frank Innes, "You are a friend of Archie Weir's?" and Innes replied, "I know Weir, but I never met Archie."

It is often not difficult to find the "Archie" in a man when you meet him, and it is extraordinary what a different opinion you have of Weir when you meet Archie. That, I know from experience, is the spirit which animates the members of this Section, and I am indeed honoured by being esteemed worthy to preside over your proceedings.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

Welfare Centres and their Work.

DEAR MR. EDITOR,—

Though the boat is at the quayside and I embark almost immediately for New Zealand, I do not feel I can let Dr. Mann's letter pass without comment.

The work which Dr. Truby King started years ago at Christchurch, New Zealand, has spread far and wide and his ideas on breast feeding are now being successfully carried out at and from the Centre, at Earl's Court, London. Among the selected charts sent me to take out to Dr. King, are two showing the successful re-establishment of lactation in slum mothers who attended as out-patients without having had the benefit of test weighing. The health and condition of mothers and children show great improvement as it did in districts where I followed Dr. King's teaching. Dr. King, himself, worked successfully in London slums prior to the war. If the employment of the married woman precludes her from feeding her infants as nature intended, that is no argument for stopping breast feeding—rather stop the employment. In America the mother is subsidised to remain at home and fulfil her duties.

Writing from an industrial centre like Bradford, subject to trade depression at any month of the year, and where women prefer the factory to maternal duties, Dr. Helen Campbell emphasises the great need of concerted action on the part of doctors, nurses and midwives "to restore breast feeding to its natural place." "Till we get breast feeding restored" she writes, "we will make little headway with infant welfare . . . . . maternity is scientifically incomplete unless it includes not only the functions of pregnancy and child birth but also of lactation . . . . . where difficulty arises, the case must be fully investigated by those who have a thorough knowledge of the technique of lactation . . . . . It is the first essential of the infant's well being."

The health of the average nursing mother is superior to that of the woman whose child is artificially fed.

In his recent presidential address to the New Jersey State Pediatric Society, Julius Levy, M.D., states:—"Maternal nursing is not merely one method of feeding an infant—it is the only right way. Even if infants thrived as well and did not die in greater numbers in the summer on the bottle, maternal nursing would still be the only right way to feed an infant, and I use the word "right" in the moral sense . . . . . The milk of the mother has been specially adapted to its young. The milk of each species is different and has been adjusted to its young, more particularly *in the percentage of proteid* it contains and the character of the curd it produces . . . . From a biological standpoint it is also clear that cow's milk is no substitute for human milk. Immune bodies and enzymes secreted by the breast add to the infant's resistance and development. Phosphorus and lecithin, important elements in the human nervous system, are not required by the calf, and they are absent in cow's milk. There are no contra indications *per se* to maternal nursing "ad infinitum.

Undoubtedly, one finds rickets in some breast-fed babies, but the origin of rickets has not yet been decided.

During the war, some authorities deplored the absence of food containg the anti-rachetic vitamine from the mother's diet as pre-disposing the infant.

In a note on rickety children by Dr. Scurfield (late M.O.H. for Sheffield), he suggests the incidence of rickets in breast-fed babies being due to unsuitable diet subsequent to weaning (*Maternity and Child Welfare Magazine*, Sept., 1921).

Although Dr. King is an enthusiast for natural feeding, he suggests that weaning should take place, gradually, between the 9–12 months, if the weather be suitable. Too frequently mother and child suffer if lactation is continued when the child's dental condition suggests a more suitable diet. I found I had better results with breast feeding where the mother got dinners free or at part cost. I had less bottle feeding, even less complemental feeding, till lactation was fully established. Too often the milk granted to the mothers goes directly to the baby. It is to be regretted that breast-eeding was continued till the 10–12 months in only 25 per cent. of Dr. Mann's cases. To quote Drs. King and Levy again, successful maternal nursing depends largely on *faith*, faith of the doctor in the ability of all mothers to nurse, faith of the mother in her ability to nurse, influenced by proper régime and nursing technique.

The use of Allenbury may be dismissed by giving the percentage composition:—

		Sugar.	Fat.	Proteid.
No. 1	...	62.0	18.5	10.0
No. 2	...	70.0	17·5	9·0
No. 3	...	80.0	1.0	10.0

Dr. Mann objects to the term "dreaded bottle," but I adhere to it. I dread it in the "West End," but more in slum tenements, where one wages war on flies, dirt, dust, and too often human apathy or despair. He writes: "The bottle is only a danger when dirty or contains dirty milk in the hands of a dirty mother"—or, we might add, over-worked mother—and these conditions are generally present, if not collectively at least singly. Moreover, where can even a clean intelligent poor mother store her milk? How can the slum mother, with few utensils and often no water "laid on," cleanse her hands, the bottle or the teat? Or if she succeeds by carrying water up many stairs in a questionably clean receptacle, how does she store the bottle and teat between feeds so as to be germproof? Flatly it is not done and the summer diarrhœa figures plainly tell the story of "the dreaded bottle."

Even in the "West End," where cleansing and storing facilities are at their best, artificial feeding is fraught with dangers, more particularly because the scientific

modification of infants' milk to the human standard has not been generally studied by the medical profession, as evidenced by the Pediatric Conference held in London in 1919. "The experienced medical officer" may order the correct diet, but the mother requires to be visited and helped by the initiated Health Visitor, who, in the present state of affairs, is probably at the other end of the district making her ever recurring monthly enquiry as to whether the finances of the family entitle them to the continuance of the milk grant. This work, I maintain, prevents the Health Visitor from visiting cases which require help and from getting in first and subsequent visits in time to establish or re-establish lactation or arrange for *complemental* feeding. There is no chance of "honest supervision" with a district of 400 births and an average of six to nine milk investigations a day besides weighing centres and clinics.

I note Dr. Mann still advocates undiluted citrated milk, though authorities such as Dr. Truby King, Prof. V. Pirquet (Vienna) and Prof. Marfan and others warn us of the great risk in departing from the protein-ratio of human milk.

Dr. King writes in his latest publication . . . "There must surely be a reason for the presence of nearly three times as much "flesh-forming material" in cow's milk as we find in human milk, just as there is an obvious reason for the milk of the whale having ten times the fat percentage. The matter is placed beyond doubt by Heubner's striking table:—

	Time by which weight is doubled.	100 parts milk contain protein.
Human ...	180 days ...	1.3
Calf ...	47 ,, ...	3.5
Pig ...	18 ,, ...	6.0
Rabbit ...	7 ,, ...	10.0 to 12.0

Lastly, how can the Ministry of Health make themselves responsible for the correct composition of the "milks" supplied? Each Centre buys what it desires, and the percentages of the foods and their caloric value vary one from the other often as far as they vary from the human standard.

The Australasian Governments entrusted to Dr. King the provision for the children of returning soldiers. Doctors and nurses who were to accompany the ships were instructed how to feed babies at sea, in the entire absence of fresh milk and without anything but small medical supplies of lactose. Of course, plenty of fruit-juice was arranged for, and gallons of Dr. King's special emulsion (New Zealand cream) was shipped. The following was the formula used for complementing breast-fed babies or for those wholly artificially fed:—

℞ Sweetened condensed milk, 3oz. = (3 level table sp.)
Unsweetened „ „ 2oz. = („ „)
N. 2 emulsion, ¾oz. = 1 level table sp. (4 tea sp.)
Water to 30oz. *Begin with 1 teaspoon and gradually increase.

Percentage composition ...	Sugar	6.33	p.c,
	Fat	2.85	p.c.
	Protein	1.6	p.c.
To give a full fat allowance 6 tea spoonsful were used ... =	Sugar	6.4	p.c.
	Fat	3.5	p.c.
	Protein	1.6	p.c.

I am, yours truly,

T. B. N. PATERSON.

The late H. T. S. Bell.

DEAR SIR,—The announcement in the GAZETTE of October 15th, of the death of H. T. Bell must have been sad news to the large section of old Guy's men who knew and admired him. In the absence of a more extended notice in the last GAZETTE I ask you to print this letter in honour of the memory of one of the finest athletes Guy's has had.

Bell became a student at Guy's in May, 1891. He lost no time in establishing his position as an athlete, for in the Hospital sports in the following July he won the 100 yards, the High Jump and the Long Jump. In the following year he won the 100 yards, and the 220 yards from scratch, but was beaten on handicap in the jumps. In the Inter-Hospital Sports of the same year he won three first's for Guy's—the 100 yards, the 220 yards in which he made a new record, 22 3-5 secs., and the High Jump.

The year 1893, however, saw Bell's finest effort in the Inter-Hospital Sports, for in that year he won four events, a performance that has not been beaten, and only once since equalled, namely last year by Steyn. At this meeting Bell won the 100 yards, the 220 yards, the high jump—beating the previous record with a splendid jump of 5 feet 8 inches—and the long jump. This was a great day for Guy's for we won no less than nine of the eleven events. In addition to the above Bell won many events at Guy's and elsewhere, and made still another record at the Hospital Sports in 1893 in the 100 yards, his time being a yard inside 10 seconds.

On the football field Bell was a very fast and clever wing three-quarter and played regularly for Guy's for four seasons, being Captain of the team in his last year. Bell was, moreover, one of the most capable men of his year, and some idea of his popularity will be gathered from the fact that when he left Guy's to return to Australia on completion of H.S., his friends and fellow residents presented him with a piece of plate.—I am, Sir. Yours, etc.,

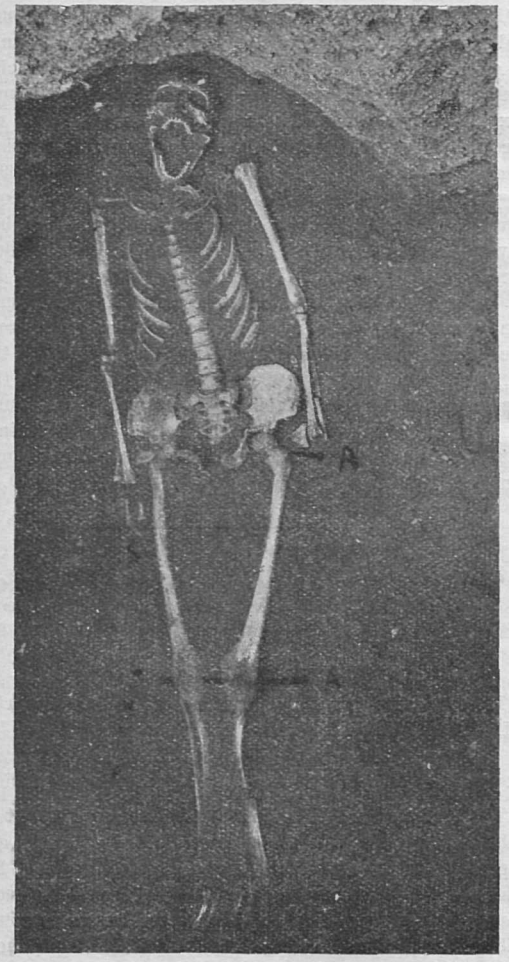
F. J. STEWARD.

98, Portland Place,
London, W. 1.

A Witch's Bones.

SIR,—I enclose herewith two photographs of the recently discovered bones of Ursula Kemp, a reputed notorious witch of St. Osyth (St. Oses), Essex, and who was buried about 1582.

The skeleton may be of interest to medical students as it shows some malformations, and the skull to dental students on account of the excellent preservation, colour and condition of the teeth. The two third right upper molars being the only teeth



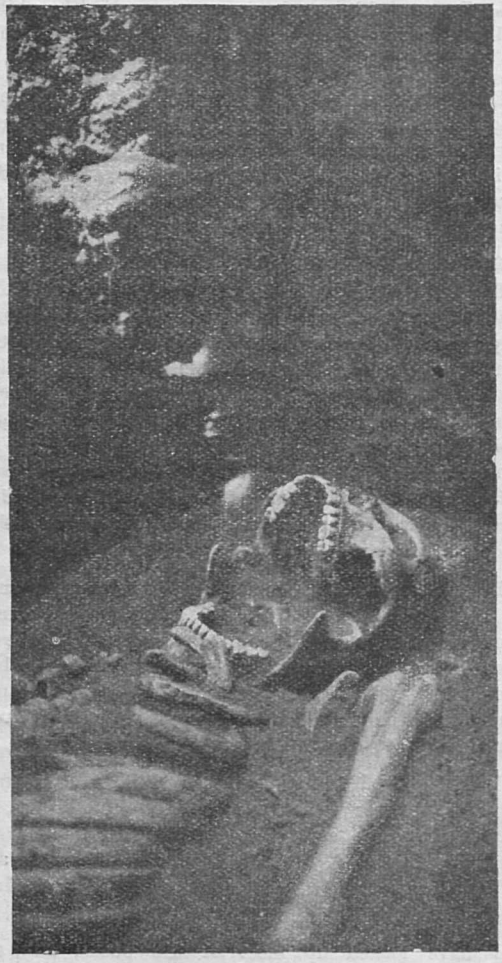
missing, probably lost during excavation. In the photo of the skeleton, at the points "A," are seen irons which were driven through the body and limbs before death, their purpose being to keep the unfortunate woman in the grave after death.

There are also irons pinning the upper part of the arms to the body and joining the ankles, but these cannot be distinguished in the photograph.

The trial seems to have been brief and in accordance with the period, one of ordeal.

The wretched woman was tied to a weighted chair and lowered into the local millstream. Had she risen the sign would have proved power as a Christian to rise after death, and consequent innocence.

She failed, was deemed a witch, "ironed" and buried alive. I suggest this last may account for the extraordinary extent to which the jaws are opened, as I found similar dislocation of the jaw in a case of three men buried alive in sand.



Ursula Kemp was tried on the accusation of her eight year old son who declared to Justices that his mother had four spirits or imps, one like a little grey cat, one like a white lamb, on black like a toad, and one black like a cat.

The skeleton will shortly be moved from St. Osyth to Colchester Museum having been accepted by the Council,

W. H. F.

Guy's Hospital, S.E. 1.
October 25th, 1921.

Femoral Hernia in Children.

Two little girls were recently in adjacent beds in Dorcas Ward, who had been operated within a few days of each other for old standing femoral herniæ of quite a fair size. The occurrence is sufficiently unusual to record.

G. F., aged 11, was a backward child, and had always been constipated. The swelling, which was on the right side, had been noticed 1½ years.

L. G., aged 12, was in every way a healthy child, and a swelling had been noticed in the left groin for four years.

The two cases were so similar that a separate description is unnecessary. In both an ill-defined swelling was present just below Poupart's ligament, which was about the size of the last joint of the thumb, was not reducible, and gave no impulse on coughing. It was said to be larger after the child had been running about all day.

The operation was done in each case by Lotheisen's method. In the first case there was a small empty sac in the inguinal canal, in the second the canal was empty. A round femoral sac was pulled up into the inguinal incision, and opened. It contained omentum only, which was matted and fibrous, and bound down by dense adhesions to the neck of the sac. The adhesions were divided, the omentum cut across, the sac tied off, and the femoral ring closed by suture of the conjoined tendon to Astley Cooper's ligament.

Femoral hernia is commoner in women than men in the proportion of 6 to 1. It is nearly always found in women over 25, usually in those who have been doing heavy work and who have borne children. In nulliparous women it is distinctly uncommon. The factor of increased abdominal pressure seems to be a distinct causative agent.

When femoral hernia occurs in children, it is said to be commoner in males than females. Coley, in Keen's Surgery, says that out of 3,404 cases of femoral hernia at the Hospital for Ruptured and Crippled, roughly 3 per cent. were in children under 14.

I have looked up most of the books, and the general view seems to be that femoral hernia is essentially an acquired condition. According to Russel Howard, the exciting causes are probably loss of fat removing some of the support of the femoral ring, straining during parturition and defæcation, and the formation of a properitoneal fatty hernia which frequently accompanies a femoral sac.

In these two children there was no such cause, unless the constipation of the first child be considered an important factor. Yet the herniæ, judged by the history and by the findings, had been present some years. This strongly suggests that the sacs were congenital in origin.

Most authors admit the possibility of some femoral herniæ, especially in children, being congenital. Hamilton Russel, who is referred to by Lawrie McGavin in Choyce's Surgery, states most emphatically that all femoral herniæ are congenital. His chief paper is in the *Lancet*, 1902, p. 1519, in which he postulates that such herniæ are due to the drawing down of a pouch of peritoneum along with the vessels in the development of the limb bud, and suggests that the direction which the hernia takes is due to the pouch following the superficial pudic, superficial epigastric, and superficial circumflex iliac vessels. His arguments are based on theory, and stated with an emphasis that provokes reserve. In a previous paper in the *Lancet*, 1899, p. 1353, he states with almost equal conviction, that all femoral herniæ are acquired. Coley believes that some of those femoral herniæ which ascend over Poupart's ligament are congenital. R. W. Murray, quoted in Thomson and Miles, supports the congenital view of Femoral hernia, and from the presence of muscle fibres at the fundus of the sac, suggests that a gubernaculum pulls down the sac. He states that femoral diverticula are found in 23 per cent. of bodies. Arthur Keith points out that such diverticula are, however, never present at birth.

W. H. O.

"If Gray Wrote our Guide Books."

The Hospital of Guy is situated in the inferior left lateral region (New Terminology, "S.E.1"). It presents for examination a body, a transverse fissure, a quadrilateral space, and two Para-Guyoids.

The *body* forms the most anterior portion. It is related on right with the Tract of Mazepond; anteriorly it is separated from the Tract of St. Thomas by a space of considerable size—the *locus innominatus*. The floor of this space shows a rough pitted area, due to degeneration of its component cells; this irregularity is stated by the older anatomists to be due to an excess of zeal on the part of the heat-regulating officials at certain periods of the year. In the centre of the space is a well-marked eminence—the *Statue of Guy*—in size and shape this closely resembles a human figure, though its weight is considerably greater.

The body is quadrilateral in shape and presents for examination two *alæ*. The greater portion of

the left ala forms the *Chapel*; the right ala contains the *Forum* or *Senate House*.

The body is traversed in an antero-posterior direction by a tunnel-shaped duct or Colonnade. Opening into this duct on either side are two diverticula which communicate freely with the sky, their roof being deficient. On the walls of the duct the student will notice the right and left lateral notice-board, and the receptaculum epistolarum (N.T., letter-box). The commencement and termination of the duct are divided into three channels by the anterior and posterior pillars respectively. The duct opens into the transverse fissure.

The *transverse fissure* is about 15 feet in width and communicates by means of a lithotic arch with the Tract of Mazepond: in so doing it pierces the external limiting membrane (N.T. Railings). The fissure serves to separate the body from two structures known as the right and left Para-Guyoids. The long axis of each Para-Guyoid runs in an antero-posterior direction. The right one terminates posteriorly in the *Department of Out-Patients,* and exhibits on its superior surface a well-developed tubercle, closely resembling in shape the crown of an Eastern potentate. The left Para-Guyoid is of a less regular outline and contains from before backwards the *Department of Massage*, the *Domus amœbæ ancillaris* (see "Report on Nursosis, Vol. xxxv., No. 865), and the *Domus Eruditionis Sapientiæque* (N.T., *Medical School*). The two Para-Guyoids are connected more or less by the *Pars intermedia* and *Pars anatomica*.

The Para-Guyoids, the Pars intermedia, and the Transverse Fissure bound a quadrilateral space or park. A portion of the floor of this space is covered with ciliated epithelium (N.T., *grass*). Arising from it are numerous vertical outgrowths or trees, which break up into a large number of branches, and which in the evening are frequently invaded by a horde of parasitic organisms—*the starlingæ*. These starlingæ are exceedingly active.

In close relation with the left end of the transverse fissure is the *Collegia*. In the lower part of this the student will not fail to notice two or three urn-shaped vesicles. On stimulation of the distal end of one of these vesicles, a slightly opaque, tasteless liquid is secreted, the colour varying from light yellow to chocolate; a name occasionally given to this secretion is "*Tea*": numerous other names, however, are often substituted for this.

Development.—The last part to appear is the Department of Massage, and the colour of this is consequently of a brighter tint than the remainder.

Nutrition.—See separate Chapters on Katabolic Activities (A.B.C.), Navis (N.T. "Ship"), and Domus Pontis (N.T. "Bridge House").

A. J. S.

Football.

RUGBY.

NOTICE.

It has become necessary once more to state the Committee's decision concerning teas for spectators. Members requiring will purchase tea tickets from the groundsman *before the commencement of play*. Only holders of tea tickets and players are admitted to the Pavilion after these matches.

The Secretary wishes to notify playing members. that much inconvenience has been caused by names not being ticked off or scratched by the mid-day previous to the match. He requests them to assist their team Secretaries by observing this custom in future.

Reserves could greatly help matters in this respect, if they would interview the offenders personally, and then inform their team Secretaries of the result of these interviews. They ought also to bring their football clothes to the Hospital on the day of play, as some members have an unhappy habit of scratching at the last minute.

GUY'S v. HARLEQUINS.

The game did not open well, for both sides took a long time to settle down. The Harlequins had a good many chances, but their threequarters were not passing well and we escaped any real anxiety. The home forwards, for the first 15 minutes, let them have the ball, but after two or three handlings the movements broke down. Now Guy's began to get the ball, but they didn't do much with it. Bekker and Sprong passed out at once, but at a standstill, which is no good. Van Schalkwijk also got rid of the ball without drawing his man, so that Albertijn always got the ball late, by which time Gracie and one or two others were waiting for him. Albertijn and Steyn showed some fine play later, and at length Steyn got away well, shook off King's tackle, and crossed, but no goal resulted. Van Schalkwijk put in some fine touch finding and was poorly supported after getting well away from an interception. The 'Quins now drove us to our "25," but Albertijn sent them back by fine play. From a scrum just after this Van Schalkwijk got going from some good passing, but final pass never reached Hirschberg, who all through the game had few opportunities. Guy's had a drop at goal from a penalty, a long shot which went just wide, and soon after half-time was taken.

The second half saw the whole XV. much better together. Sprong played like a different being, and Bekker's excellent work had a better reward, but

still no score came our way. The Harlequin forwards fell away, and our foothold in their half was persistent. King, their full back, was splendid, again and again he tackled, and his kicking was fine in length and direction. Our full back, Crisp, was very good, but he had nothing to do compared with King. A good effort by Fouraker was poorly supported. We made many attacks through our threequarters, but there was scarcely enough determination in their work; till 20 minutes before the end Albertijn, who has never played better, was only kept out by the excellent work of King, then a fine run by the same player ended in Van Schalkwijk scoring. Neser just missed goal because the ball was placed badly. Then followed some dashing and clever play by Steyn, who at length cross kicked for Albertijn to field and give to Neser, who scored by the post. Van Schalkwijk had no difficulty in converting this try. Just before the end Neser kicked a difficult penalty goal.

Neser, Duncan and Fouraker were the pick of a very lively pack, and one which with good luck will go far. Result—Guy's—2 goals (1 penalty), 2 tries (14 points), Harlequins, Nil.

Guy's Team—E. J. Crisp, A Hirschberg, J. G. Van Schalkwijk, P. K. Albertijn, C. L. Steyn, F. Bekker, E. L. Sprong, W. D. Doherty, R. F. H. Duncan, E. E. Neser, W. H. Taylor, G. Zondagh, E. H. Fouraker, L. K. Watson, P. G. Harvey.

GUY'S v. OLD BLUES.

As the Old Blues new field was not ready for play this match was played at Honor Oak. A large number of spectators witnessed the match, which was a well-fought one from start to finish. The Hospital had to do without Taylor, who was playing at Redruth for Cornwall; while Shelswell and Watson were also absent. The Old Blues had substitutes among their backs. At full back they were splendidly served by H. W. F. Franklin, a finely built player, at present resident at Oxford. His tackling was splendidly thorough, and the Old Blues have cause to be grateful to him. For the first 15 minutes the Old Blues were sorely pressed, but their forwards (they play seven forwards and eight backs) bustled our men a good deal, and when the ball came out their side Bridel was particularly dangerous. Then Doherty got his forwards more together and Harvey was almost over, while just after Bekker made a characteristic dive for the line, but without success. From the next scrum, however, he sent the ball out to Sprong who scored wide out. Neser kicked a very fine goal. A brilliant interception by Hodgson put our line in danger and we only escaped by touching down. From a short line out, Steyn got clean away, but though he had heaps of room to go inwards, he hugged the line and Franklin floored him. Then came a startling run by Mills and Bridel for the Old Blues. The latter had Steyn and Albertijn fairly guessing with his twisting and dodging. The game was soon back at the other end, the result of dashing play by Neser and Duncan. Then Fouraker got possession and got over easily. Neser's kick was good, but not successful.

After half-time we tried 7 forwards, Neser going back and Van Schalkwijk going among the threequarters. It was difficult to see the object of the change. It certainly benefited us but little, for we failed to score in this second half. The Old Blues scored a try by Hodgson right by the post, but the place kick failed, though the kick was an easy one. Almost immediately the Old Blues crossed the line again, but this time a scrum was ordered. At times Guy's attacked well, but no further scoring took place. Much of our threequarter work was excellent, though the ball was occasionally "ballooned" rather haphazardly, so much so that on one or two dangerous occasions an opponent captured it as it fell. High "hopeful"—or rather hopeless—passes are useless. Sprong stands much too close to Bekker and is too fond of the blind side instead of seeking the greater space and making the utmost use of the fine line behind him. The forwards want more "ginger" and will do well to keep more together in the rushes, and go when they do rush with all their might.

Result:—Guy's, 1 goal 1 try (8 points), Old Blues 1 try (3 points).

Guy's Team—J. G. Van Schalkwijk, A. Hirschberg, H. Graham-Davies, P. K. Albertijn, C. L. Steyn, F. Bekker, E. L. Sprong, W. D. Doherty, H. Fouraker, H. G. Close, P. G. Harvey, G. G. T. Tregarthen.

Guy's Hospital Dental School.

The following have been appointed Student Demonstrators of Dental Metallurgy until December 31st, 1921:—

Mr. J. S. Dick. Mr. W. E. Herbert.

Marriage.

GRIFFITH—JONES.—At. Andrew's Church, Boscombe, by the Rev. A. P. Annaud, Dr. R. T. Griffith, of New Quay, Cardiganshire, to Dorothy, youngest daughter of the late Dr. J. T. Jones, of Llanselin, and Mrs. Jones, of New Quay, Cardiganshire.

Death.

HORSLEY.—On November 8th, 1921, at 1, Poplar Walk, Croydon, Henry Horsley, M.R.C.S., aged 83.

Ed.—A. T. R.

GUY'S HOSPITAL GAZETTE.

VOL. XXXV., No. 871.] NOVEMBER 26, 1921. [NINEPENCE.

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Passim.

WE regret that our short paragraph in the last GAZETTE, on the needs of the War Memorial Fund, has met so far with a shockingly poor response. The Hon. Treasurer has not received the £200 which he asked for, nor is he likely to for many years if the present rate of subscription is not increased. He has not even received two hundred halfpence. Are our memories so short as this? or our purse-strings so tight? Let us not lay ourselves open to the indignity of having to borrow money to pay to honour our own dead.

GUY'S, ever since it possessed a dental school, has boasted of the manifold advantages of the union of a medical and a dental school in the one institution. Again and again it has been impressed upon us that the communal teaching possible at a Hospital with two schools is of an extraordinary value to both dental and medical students. The dentists, we are told, learn all about the influence of dental sepsis on systemic diseases, and will in consequence be ready to remove every tooth in a patient's head if the medical man desires it. The doctor-to-be learns in his turn how much better one's own teeth are than any bought from any dentist, and so becomes chary of asking for teeth to be removed without good and sufficient cause.

If the ideal were to be possible, such things would be, but at present, except in sport, there is very little union between the two schools. At Rugby, at tennis, or at athletics, the two schools, with the greatest zest, pull together for the common good. But in the workaday life, the dental man eschews the medical, and the medical the dental. Each goes his own way and will have nothing to do (if he can help it) with the other.

The dental student learns all that the dental surgeon will teach him, and too often turns a deaf ear to the teachings of the physician, while the medical student will not see that a tooth in the jaw is better than two in a denture. Thus it is that a patient with rheumatoid arthritis can still go along to Dental Out-Patients with a filthy mouth and the customary chit—"Will Dental H.S. please see and treat oral sepsis"—and come back a fortnight later with his teeth scaled and his pyorrhœa as obvious as ever.

We do not wish that all dentists should be made amateur doctors, nor even that all doctors should become amateur dentists, but we do think that there is an opportunity constantly before us, which we fail to seize upon, of making the union of the schools a whole-

hearted and enthusiastic one. We must get together. The time must soon come when it will be impossible for one of the official forms to be sent back with an accompanying note (this is a no joke, but a sad and solemn fact), saying, "This form must be signed by the Full Pyhsician and not by the House Pyhsician." [We feel sure that the gentleman who wrote this would not like to be called a *Dnetist*.]

Those who trouble to look at the list of interesting cases, which we publish each week in the Gazette, will no doubt be surprised to find there are no cases recorded in Dr. Fawcett's beds in Stephen and Esther. This is not because there are no interesting cases at present warded under him, but is a purposeful omission which we have made at the request of the Clinicals. It is only natural, that, as the Clinicals have the pick of all cases presenting themselves for admission to the Hospital, the Clinical beds should always contain interesting cases. This is only too well realised by men who are studying for examinations in medicine, and in consequence there is scarcely an hour passes during the day but some man wanders into Stephen, and proceeds to examine the latest Clinical case. So much has this been the case that patients, who have been taken in ill, have been subjected almost for the whole day to repeated examinations by assiduous candidates. This ought not to be. In the old days when Clinicals had a ward to themselves no-one was allowed to visit their cases uninvited. Conditions now are different. There are more clerks and fewer beds, so that it is difficult to forbid men to take the fullest advantage of all clinical experience that is offered them, but we think that their thirst for knowledge should not displace their consideration for the patients.

The Rugby team are maintaining their high standard. Though they are not compiling huge scores, as they did last season, they are meeting some of the best teams in the country, and are more than maintaining their own. It is no mean feat to have beaten three such teams as Cambridge, Coventry, and Plymouth Albion in one fortnight. There are still, however, some hard games to be played, not the least of which is the one against Oxford, on Wednesday next, at Honor Oak Park. It is, we believe, nearly twenty years since Guy's beat the two Universities in a single season. Now, having beaten Cambridge (who of late years have always proved to be our more formidable opponents), we have an opportunity of repeating this feat. We will do well, however, not to be too sanguine over this result, and the Guy's men will need all their skill and all the encouragement which a yelling mob can give to them. So we hope to see you all there—yelling.

We publish among our sporting news a paragraph taken from "The Isis," which gives a breezy account of the recent meeting of Guy's and Oxford boxers. Although we returned from Oxford defeated, this fixture was of great value to our men, who would be only too pleased if more such engagements could be arranged. It gave a far better test of the capabilities of the different men than any amount of practice could, and, over and above this it was a most enjoyable meeting. We do not wonder that the "Isis's" reporter enjoyed the David and Goliath battle between S. P. Meacock and Alf Hewitt. It is always amusing to watch the strenuous way in which the featherweight tries to batter his instructor, and the easy way in which Alf. seems not to mind whether the blows reach him or not.

THE woodpaving in the Quadrangle, which was spoilt two years ago by our last bonfire, has at last been replaced by new blocks, and nothing is now left to remind us of the destructive folly of the old time New Year's Eve.

DURING the past fortnight a memorial has been issued signed (among others) by two of the best known Guy's surgeons, Sir Arbuthnot Lane and Sir Alfred Fripp, which asks that some honour be given to Mr. Barker, the bonesetter. This we think is a wise and graceful act on the part of legitimate surgeons, who thus acknowledge the skill of a man who has perfected one special branch of surgical technique. This is a far better way of paying tribute to Mr. Barker's skill than the granting of a medical degree to him would have been. Mr. Barker already has fame, prestige and practice. If he were given a degree he would gain little, and we would have lost our right to say "No" to any and every quack, who had hit upon some new line of treatment, and who came to us asking to be given a degree for his pains. While we have no doubt that Mr. Barker, if granted a degree would use its privileges in no unfair way, we have no guarantee that all those who would follow in his train would be as scrupulous. We cannot afford to set up so dangerous a precedent.

THE last number of the first volume of the new "Reports" has now been issued. Good wine needs no bush, and in like manner the "Reports" need no recommendation to readers of the GAZETTE. Our duty is but to say "the 'Reports' have been issued," yours the pleasurable one of obtaining and absorbing your copy.

SOME of the most observant of our readers may have noticed a paucity of book reviews in recent GAZETTES. This is no fault of the publishers, who still steadily send us books for the judicious criticism of our staff of reviewers. It is the fault of the reviewers themselves. We have besought, cajoled, even summarily ordered them, to send in their opinions of the books we have sent to them, but in many cases all our efforts have been in vain. So (needing another paragraph for "Passim" this week) we have taken this opportunity of publicly denouncing them in the hope that their sense of self-respect or of shame (if reviewers have either) will impel them at once to sit down and dash off their brilliant criticisms for us.

Nomenclature.

BY A THIRTY-SECOND YEAR MAN.

Scientific people are universally characterised by a passion for giving names to everything within their ken. It is doubtful even that if (as lesser mortals are) they were compelled to give away a silver mug every time they acted as godfathers, they would be able to curb this singular propensity. Nothing to them is complete without a name, and when, as occasionally happens, they cannot find a name which can be considered suitable even by their elastic standards, are they disheartened? No! They promptly call the thing "innominate." Just that; only another name for the wretched student to remember; only (I hope) another blot on the Recording Angel's record.

Nowadays, not only do we have to learn some thousands of names, but we have to learn some more thousands of New Terminology alternatives for those names. I suppose the next step will be to compel us to learn anatomy in French as well. The one bright spot in the whole situation is the fact that there exists, between Transversalis and Obliquus Internus Abdominis, an arterial branch, which, although very constant "has not yet risen to the dignity of a name!

Rugby Football Club.

There will be a General Meeting of this Club in the Physiological Theatre on Monday next, the 28th November, at 4.15 p.m. All members are requested to be present and to take part in any discussion that may arise.

Pass List.

University of London.

3rd (M.B., B.S.) Examination for Medical Degrees, October, 1921.

Pass.

W. M. Brown.
Alan McKenzie.
S. Rose.
K. M. C. Woodruff.
W. H. Simmons.

Group II.

E. Biddle.
E. E. D. Gray.
S. H. Robinson.

Royal College of Surgeons.

L.D.S.

Final Examination, November, 1921.

The following candidates have now completed their Examinations—

H. H. Pickett.
F. Woodford.
H. J. Barrand.
T. E. Brenetor.
I. Broude.
H. C. Churchill.
P. N. C. Conway-Jones.
F. W. Crook.
J. L. de Kock.
J. I. de Villiers.
D. J. Du Buisson.
F. J. Farmer.
W. M. K. Gray.
A. Havenga.
F. R. Hogbin.
G. K. Jennings.
B. J. M. Keyter.
O. F. A. Krause.
J. A. Krige.
J. Lancester.
A. S. Landsler.
S. Levinson.
H. J. Luck.
C. R. Hardwick.
W. J. Olivier.
E. C. Packham.
O. F. R. Painter.
E. M. Power.
G. E. Price.
G. P. Pritchard.
S. H. Rands.
H. J. Raubenheimer.
J. H. Reid.
W. E. Silver.
F. W. Van der Hoven.
H. Van Zyl.
H. R. Ward.
G. S. W. Willis.
T. E. Withers.
J. H. Broadhead.
A. W. Greenwood.
J. S. Smith.

Part I.

R. Van Geuns.
A. K. Van Niekerk.
F. W. Watt.
P. G. Trafford.
R. Koenig.
O. H. M. Woodbridge.
V. St. J. Alexander.
J. F. Allen.
R. C. Andrews.
H. K. Banks.
C. V. T. Baugh.
G. Beamish.
C. C. Brattle.
A. Clarke.
J. H. R. Creasy.
K. W. Eady.
L. G. Gray.
L. S. de Van Toit.
J. C. Faure.
F. J. Fourie.
A. S. Garland.
A. V. Goodson.
G. G. T. Haynes.
W. J. Hide.
K. Hooper.
R. Hughes.
G. B. Kempster.
*E. M. D. Mackie.
A. A. R. Madgwick.
J. U. Human.
F. A. Meyer.
H. F. Miles.
B. R. Moore.
D. A. Parsons.
P. Pienaar.
H. Radin.
B. Rubenstein.
M. Rubinstein.
H. V. R. Sellers.
K. G. Sharnill.
G. L. Shearar.
D. J. Stofberg.
W. A. Strickland.
L. N. Theron.

*Anatomy and Physiology only.

Sir Alfred Fripp's Address at the Opening Meeting of the Physical Society.

(*Continued*).

Those who elect to work in the fields of private practice must remember the difference between being educated and being clever. No degree will carry you to success unless you succeed in developing those personal qualities which are wanted by your public. Mere talents may suffice in a Government Service or in any branch of Research or of Academic life, but you want something more to earn success as a practitioner—you have to study the humanities, the art of life.

In no walk of life is it more true that the proper study of mankind is man. Cultivate the art of listening, learn to grasp the essentials of the situation, to be quick in the uptake—so you will learn to treat the individual as well as the disease, and to allow for his temperament and his tastes. You will realise the value of that kindly word which puts people at their best, the danger of first impressions and impulses, and the desirability of postponing judgment where you can without detriment. Thus you will search for solid ground affording sure footing and standing on the definite and proved, you will find abundant opportunities for peering out into the indefinite and watching developments and wondering how soon the pendulum will show the inevitable back-swing from the extreme to which it is always pushed by the enthusiastic discoverer. Faddists and fanatics and even rascals there always have been and there always will be, both within and without our profession. It takes all sorts to make a world. They flourish upon the rustic ignorance of the public in matters of health. Watch them, and more closely still if they come in attractive guise, and don't swallow assertions just because they are novel or bizarre. Buy truth but never sell it. Beware of the medical or surgical stunt.

Practice organisation from your earliest years. Plan your work, plan your hours, you will economise time and effort.

Team-work and group systems have produced excellent work in the past, in sport as well as in work, but each man has got to

fight his battle of life alone and professional slogans are not going to help him.

Enlarge your experience by grasping every opportunity of travel, either on a large or small scale, and by devoting such reading time as can be spared from your professional work to the great writers. By this means you will combat that tendency to narrowness of outlook, or grooviness, which too often stamps men who have to lead the strenuous and exacting life of the hospital. And each of us however busy can find time for general reading, especially if we avoid the waste of time which is entailed by poring over a multiplicity of newspapers and magazines, and by indulging inordinately in games, whether of cards or what not, to which no health or other profit attaches. To put it another way spend your time rather over such pursuits as will help you to create a demand. It is not enough only to supply a demand.

Practise speaking in public. You will be surprised how much it tends to clarify your views, and what a degree of confidence quickly comes as soon as you have got over the feeling of shyness and novelty which besets every man the first time he hears his own—apparently extraordinary—voice in public. N.B.—This Pupils' Physical Society provides you with just the opportunity you want.

Avoid appearing to be in a hurry. Celerity as distinguished from haste, should be the accomplishment rather than the obvious aim of the surgeon. As a very worldly-wise lady once said to me "The greater his need for hurry the more the necessity for the doctor to take a chair and sit down as if he had plenty of time to devote to this patient should the case demand it."

Avoid pathological details in your report to the patient or to his relations. They will not be understood and very likely will be misinterpreted.

Seldom tell a patient about "a case in point"—it will profit neither him nor you.

Always remember *never* to use those two words in our profession.

Differentiate your Sundays. The regular holidays, even the regular sleep at nights, which can be relied upon by other professional men however busy they are, are denied to us, and no man can work all the days of the doctor's year without detriment. One day in seven should be spared all but absolutely essential work.

In order that you may make as few professional side slips as possible be ready with your next step—the doctor who shows obvious hesitation is lost. Realise the moment when it comes, that it is better to take any step however desperate than to leave the patient to die, if there is any chance of avoiding that certainty.

Surgery is not only a question—is not so much a question—of what can be done—given anæsthesia and a circular saw there are no limits; but rather a question of what should be done. "Brilliant operation—patient dead," is not a bulletin that is helpful to you or to your great profession. Beware of operations done for pain alone—unsupported, that is, by other indications. It is safer in surgery to begin with a little scepticism.

Don't operate without asking yourself the reason why. Only all acute abdomens and some obvious tumours and traumas should be operated upon without first calling a modern physician into consultation if such is available.

The surgeon whose statistics show 100 per cent. of success is a danger-spot; he is not fit to be a surgeon, for he is—well, an economiser of the truth—for no operation has ever earned 100 per cent. of success, or ever will. He will do less harm to the profession and to himself in the long run if he confines himself to fishing stories. You remember that classification of liars by some lawyer into Liars, Damned Liars and Skilled Witnesses? Our experience would put a fourth class at the end—and that is Drug-Maniacs.

Don't forget that there is a right and a wrong way of doing everything—however apparently trifling. To give an instance of what I mean, to get your hands surgically clean is more difficult than the uninitiated would think—and it is impossible until you have learnt to eliminate all lesions of the epidermis, and to avoid soiling them by putting on gloves before you examine a dirty case. Prevention is better than cure. It is not easy always to do anything—even the most trifling—properly. Concentration and painstaking practice are essential, and even when you have acquired an art don't let familiarity breed contempt. Take care of details—a burnt heel and musculospiral paralysis go far to mar the impressions of a successful operation. Indeed surgery is a craft as well as an art and a science, and there is room for gentleness, forethought and consideration as well as for dexterity and cleanliness.

But I am getting too much on to my own speciality—and reminding myself of that tiresome raconteur who is for ever remembering "a case I saw recently." No doubt it is very interesting to him, but it may not be just what you want to talk about. If you must tell a story let it be strictly à propos and short and not of the nature of that "Total recall" which one associated with mental degeneration—nor let it smack of "capping his."

Let me get back—on to a short list of don'ts, which apply to all branches of practice.

Don't frighten people by making a dangerous diagnosis at the first interview—unless it is to the detriment of the patient to wait till tomorrow.

Don't interfere outside your job if you can possibly avoid it.

Don't give the patient just so long to live. you may be wrong, even the youngest among us is not omniscient.

Don't forget that they are all patients, which means ill people, and therefore are not their normal selves. We are told there is no such thing as a normal man or woman—there is only an average. Too much variation from the average justifies the expression—abnormal. No two patients are alike, no two doctors are quite alike, there is always the personal equation, and no two cases are quite alike either. Hence a large share of the charm of our daily work. It is never really monotonous.

So whenever you pay a visit don't leave the house till in one way or another you have made them feel they have had their money's worth of you, which they won't if all you say is, "I will see the patient again to-morrow."

As far as possible keep your eyes and your ears open and your mouth shut, and then you will avoid that tiresome complaint which George Eliot dubbed logorrhœa, and you will note and banish from your conduct the points that raise a laugh when a doctor is personified on the stage.

Nearly fifty years ago an early worker in the field of tonsils and adenoids published a book entitled, "Shut your mouth and save your life." It is a pity it has been forgotten.

"It's not the man who knows the most as has
the most to say,
It's not the man who has the most as gives
the most away."

Be magnanimous to your rivals as long as they are straight.

Patients will leave you and go into the camp of your rival—and for many causes—mostly trivial and unreasonable, though often the explanation is quite simple and natural.

Oddly enough, incompetence is the rarest of causes.

Such, and other, disappointments must occur to each of you. Don't let them worry you or make you jealous, but keep a stiff upper lip and play the game.

Others leave your rivals and come to you; and for no better reason, so don't get swelled head!

Do we always remember that doctors are made for patients—not patients for doctors? Are we open minded enough as a profession? Are we not rather too apt to think that our orthodox text-books contain everything it is good for us to know, or for the public to have recourse to? Are we quite proud of the attitude our profession has in the past adopted towards any advance in the methods of doing good brought forward by the unorthodox, *e.g.*, the homœopaths, the bone-setters, the psychotherapists and the other "healers"? Have not we sometimes taken rather a worm's eye view, as an American friend put it, of these matters, and has that attitude increased our standing in the eyes of the public? and would it not be better for us and for them if we showed ourselves willing sometimes to get the beam out of our own eye first?

There is always a tendency to think one knows better than others, or at least has little to learn from experience. Didn't somebody call this attitude of mind the airy complacency of ineptitude? These are the individuals who are for ever "going in from the deep end" and then excusing themselves by saying, "Who'd have thought it?"

Try to avoid self-satisfaction, rather look upon every experience as being of importance. The capacity for assimilating what is useful from his environment is one of the greatest essentials of success in our profession, therefore think of nothing as alien to you.

Do we always realise how much good or how much harm we can do to each patient by our words, by our manner, by our expression? Every patient feels better or worse for having seen his doctor—and he hopes to feel better—unless he belongs to that comparatively small class that "enjoys bad health."

Every patient is therefore in a receptive or suggestible condition, and a sacred trust is reposed in you to make the effect upon him of your presence productive of as much benefit to his case as possible.

Assiduousness and devotion to your patients' interests will carry you further than all the talents.

With each and every patient your interview is a crisis in his day, if not in his life. So no complaint that incommodes is "trifling." I believe it was Gull who said, "A pimple on his nose is more important to him than a cancer on his neighbour's thigh."

Finally, the higher you rise the more people can see you to fling mud at you. Few are able to carry success without some friends discovering symptoms of swelled head, but I hope you may achieve the one without the other, and that "as you go up the hill of prosperity you may never meet a friend."

Yet it is certain that success cannot come to all of you, nor can you all keep your health; but happiness is within everybody's grasp, whether he is successful or not; even whether he is healthy or not. Many of the greatest invalids have been happy and have radiated happiness to others. It is almost entirely the individual's fault if he is not happy, for happiness is a cast of mind. One of the greatest lines of the greatest of all poets says, "There is nothing either good or bad"—in this world—"but thinking makes it so." Happiness resides not in the pocket nor even in the bodily health, but in our mental attitude to our surroundings and in contentment with our lot. We cannot entirely govern our surroundings, but each of us is captain of his own soul. Thank God for what you have got. It is quite easy to be wretched though rich and healthy. There are several ways, but the surest of all is to permit jealousy of others for having got something you have not. I would go so far as to say that among all the really rich I have met I have rarely met a really happy one; far more often have I met contentment and happiness under straitened circumstances. A wealthy man once said, "You may own a quarter of a million, but half a million owns you," and it is an open question whether too much success, like too much money, is not fraught with anxiety and distrust of others. Success and happiness in fact are often far removed.

Happiness is an art. Like all arts it requires fostering by practice till it becomes a habit—and any man or woman may acquire it.

One very successful doctor said it was impossible to be happy in our profession unless you made it a rule to avoid three obstacles—viz., (a) all hopeless cases, (b) the giving of professional advice to your own and your wife's relations, (c) all cases of sciatica and mucous colitis. Now, obviously, this was, if not a counsel of perfection, a quite impossible ideal to strive after. And it was merely destructive criticism, which is always easy and seldom valuable. Let us try to make a list of some of the precepts of what Dr. Tidy, I think it was, called "The Art of Happiness," only don't let me give you the impression that I am either trying to sketch a Utopia, or to make a complete catalogue of all the virtues, or even to put such as are mentioned into any sort of order of merit.

1. First of all a very simple thing:—Just be yourself happily. Each of you has a personality—an aura—a temperament. Don't try to copy others.

2. Study the art of being kind and considerate, and trying to help. Always "Remember your next behind," as the Captain of a battleship had stuck up to remind the man at the wheel that the safety of those following depends upon the course you steer.

"There are many Gods and many creeds"—
you remember that—
"And many paths that wind and wind;
But all this old world really needs
Is just the art of being kind."

(To be concluded).

Interesting Cases in the Wards.

Under Dr. French and Dr. Poulton—

Addison 28. Tropical abscess.
45. Chronic pancreatitis.
44. Congenital heart disease.

Under Dr. Beddard and Dr. Mutch—

Esther 4. Mitral stenosis.

Under Dr. Hurst and Dr. Hunt—

Addison 21. Aortic stenosis and regurgitation.

Systolic Murmurs.

CLINICAL LECTURE BY DR. G. H. HUNT.

GENTLEMEN,—Systolic murmurs have for many years been a subject of interest to physicians. In any text book of medicine you will find various explanations given for their presence, and in the wards you will hear discussions on the structural conditions that may produce them, but even so it cannot be said that the problem of their origin has been completely solved, so difficult is it accurately to understand the physics of the circulation.

More recently controversy has turned from the mechanical causation of murmurs to their significance. From the practical point of view this question is of very great importance, for the significance you attach to a murmur must affect your decision as to whether the heart is sound, and so will materially influence your treatment. This is particularly the case in patients in whom you find a systolic murmur, but no other evidence of cardiac abnormality; in such patients you must make up your mind quite definitely as to whether the murmur is of any practical importance or merely of academic interest. In hospital practice—at any rate in the wards, where the large majority of cardiac patients have obvious signs of organic disease—this problem does not arise nearly so frequently as in private practice; particularly is this the case among the more educated class of patients, who have heard of murmurs, and have that little knowledge which is such a dangerous thing, and such patients may consult you simply because they have been told they have a murmur. A parent, for example, brings his son: "John has a murmur, may he play football?" It is easy to be on the safe side, and forbid football, but remember that not only do you deprive John of the pleasure of the game, but you brand him as an invalid among a crowd of healthy boys. Or perhaps a man in busy professional or commercial life, who is not feeling quite so well as usual, remembers being told in former years that he had a murmur, and asks you whether his heart is strong enough to stand the strain of hard work and anxiety, or whether he ought to retire and be content with half his present income. In such cases you will have to make a definite decision on the significance of the murmur; a mistake may have serious consequences, for to allow a man with organic heart disease to lead exactly the same life as a perfectly healthy man will hasten a breakdown of compensation, and on the other hand to impose restrictions on a man with a sound heart will unnecessarily limit his activities, and cause him needless anxiety.

Many years ago there was too great an inclination to regard every cardiac murmur as an indication of heart disease; recently opinion has veered in the opposite direction, and among some cardiologists there is a tendency to consider systolic murmurs to be of no importance. I propose to-day to describe to you the various systolic murmurs commonly encountered, and to attempt to outline the principles on which their significance should be estimated.

I shall confine myself entirely to a description of systolic murmurs, and shall not attempt to describe the characters or significance of diastolic murmurs, and before starting to describe systolic murmurs I must make clear to you the exact meaning I shall attach to the term "functional," for it is applied to cardiac murmurs by different writers with very varying significance.

I shall use it to describe murmurs which are not due to structural change, such as endocarditis, myocarditis, causing dilatation of the heart muscle, or atheroma, causing dilatation of the aorta. Under the heading "functional murmurs" I shall include murmurs sometimes described as "accidental," "hæmic" or "cardio-pulmonary."

For purposes of description it is convenient to divide systolic murmurs into two groups according to the positions where they are of greatest intensity. In group 1 we have murmurs which are best heard over the base of the heart, in group 2 murmurs which are best heard over the apex.

Group 1.—This comprises (a) the murmurs of aortic and pulmonary stenosis; (b) the murmur due to atheroma of the aorta; (c) the so-called functional murmur.

(a) The murmurs due to aortic and pulmonary stenosis (whether the stenosis is due to adhesion of the cusps of the valves or to the rarer condition of narrowing of the vessel above the valves) are usually easily distinguished from those of the other two groups (b) and (c), for they are very loud and harsh

in quality and usually accompanied by an easily detected thrill. Stenosis of the aortic valves is nearly always accompanied by aortic regurgitation; indeed so rare is it to find pure aortic stenosis, that it is unjustifiable to diagnose it unless the systolic murmur is followed by the diastolic murmur of regurgitation. In any case I would like to impress upon you that aortic stenosis is not a common condition; I have frequently asked students the commonest cause of a basal systolic murmur, and the answer is usually "Aortic Stenosis." Pulmonary stenosis is a commoner condition, and, as you know, is one of the forms of congenital heart disease; you must not, however, always expect to find all the classical signs of congenital heart disease, cyanosis, polycythæmia and clubbed fingers, associated with it, for they are absent in nearly half the cases. You will find described many points distinguishing the murmurs of aortic and pulmonary stenosis from each other; the aortic murmur is better conducted into the neck than the pulmonary; the aortic murmur is better heard over the second right space, and the pulmonary over the second left space, but you will often have difficulty in deciding the point of greater intensity, so close is the aortic to the pulmonary area. By far the best diagnostic point is afforded by the presence or absence of a diastolic murmur; if a diastolic murmur is present the lesion is aortic, if it is not present the lesion is pulmonary.

(b) The murmur due to atheroma of the aorta is fairly frequent in middle-aged patients, particularly in syphilitic subjects, and with this can be grouped those cases in which the disease has resulted in dilatation of the aorta with the formation of an aneurism. This murmur resembles that of aortic stenosis in position and in the way in which it is conducted, but rarely attains the same intensity, being usually much softer and rarely associated with a thrill. X-ray examination is of value in these cases, for even in the absence of a definite aneurism the aortic shadow is often found to be slightly broader and longer than normal, and this will clinch the diagnosis in doubtful cases.

(c) The functional murmur. I have already defined this as a murmur not due to endocarditis, myocarditis or aortic atheroma. This is met with in many cases of anæmia; it is for example frequent in women suffering from chlorosis, and is invariably heard in the later stages of pernicious anæmia. It is, however, not confined to patients with anæmia, for it is not infrequent in young men in perfect health. It is also common in pyrexial patients, whatever the cause of the fever. This murmur may be difficult to diagnose from those in groups (a) and (b), but it has the following distinguishing characteristics:—

1. It is generally soft and never attains the intensity of the murmur of aortic stenosis.

2. It is never accompanied by a thrill.

3. It is usually better heard when the patient is lying down than when he is standing, although occasionally the reverse is the case.

4. It often varies with the breathing and in some phases of respiration may completely disappear.

5. Except in cases of severe anæmia it is not accompanied by any alteration in the size of the heart.

6. It may be audible at the apex, but in this case it usually reaches its maximum intensity at the base.

7. It is usually localised, and is rarely conducted far and never audible at the back.

8. It only modifies and does not replace the first sound.

A good deal has been written on the importance of estimating the exact duration of murmurs, and it has been held that the functional murmur only occupies a portion of the systolic period, whereas the murmur due to actual regurgitation lasts throughout the whole of systole; there is, however, so much difference of opinion on this point, and the difficulties of accurately measuring the duration of a murmur are so great, that a distinction based on such observations is of little practical utility.

Group 2.—Murmurs best heard over the apex.

This group comprises (a) the murmur of mitral regurgitation; (b) the functional mitral murmur.

(a) Mitral regurgitation can be caused in two ways. In the first place it may be the result of endocarditis of the mitral valve; in the acute or subacute stages of the inflammation vegetations are formed on the valves, and these, if sufficiently large, will give rise to a leak by holding apart neighbouring portions of the cusps so that regurgitant streams occur on either side of them; in the later stages the

cusps of the valve become thickened and shortened, so that they are not competent to close the mitral orifice. In the second place mitral regurgitation may be the result of weakness of some part of the heart muscle; relaxation of the muscle surrounding the mitral ring will cause an increase in size of the orifice and consequently imperfect closure during systole. Weakness of the papillary muscles may also cause insufficiency; their function is to prevent too great an excursion of the mitral cusps, and if their tone is not sufficient to antagonise the pressure of the contracting ventricle, the cusps of the valve are pushed upward beyond the point of closure.

The commonest cause of mitral endocarditis is acute rheumatism, and in this disease the inflammation is seldom confined to the endocardium; it affects all parts of the heart, endocardium, myocardium and pericardium. The myocardial inflammation leads to dilatation of the heart muscle, and for this reason we frequently find that a mitral leak is due to a simultaneous endocardial and myocardial lesion.

In young subjects it is generally impossible to say which factor predominates in causing the insufficiency; it is sometimes claimed that the quality of the murmur is a distinguishing feature, and I think it is true that very harsh murmurs are usually endocardial, but when this characteristic is absent a differential diagnosis is impossible. In older patients, suffering from myocardial degeneration, mitral regurgitation is more often the result of a stretched muscle than of endocarditis. The difficulty in differential diagnosis is not, however, a matter of great moment, as I hope to show you presently; it is of far greater importance to distinguish the murmur of mitral regurgitation from the functional murmur.

(b) The functional mitral murmur. This murmur is very frequently met with although it is less common than functional basal murmur; Potain found that functional murmurs (including basal and apical murmurs) occurred in one-eighth of the patients seen in his hospital; possibly this figure is unusually high, but I should say from my own experience that the proportion does not fall far short of this. I have already enumerated points distinguishing a functional basal murmur from an organic one; they all apply equally to the differential diagnosis of mitral murmurs with this exception; although it is true that the harsher murmurs are caused by regurgitation many of those of softer quality are not functional. Perhaps the best example of this is seen in cases of acute rheumatism. A child comes into hospital with all the arthritic signs of acute rheumatism, but without any evidence of cardiac involvement; with treatment the joint pains subside, and the temperature and pulse rate fall; a few days later the pulse rate may begin to increase (often without any increase of temperature), and when the rise has reached, say, twenty beats per minute, a soft systolic murmur becomes audible at the apex which may persist or disappear. It is difficult to believe that this murmur, in spite of its soft character, is not due to regurgitation through the mitral valve, occurring as it does in the course of a disease known to damage the heart and in association with a rise of pulse rate, a sure indication of myocardial inflammation.

We can then summarise the chief characteristics of functional murmurs, whatever their position, as follows: they are soft in character, they do not replace the first sound, they are not well conducted, they are better heard with the patient recumbent than erect. None of these characteristics are invariably found, and there are cases in which considerable doubt must exist as to the exact nature of a systolic murmur, but if you will bear in mind the points I have mentioned, I think you will be able to say in the great majority of cases whether a murmur is due to some organic heart defect, valvular or myocardial, or whether it is a sign that does not indicate structural change.

The significance of systolic murmurs.—I do not intend to discuss this in all the conditions in which it may occur, for in some the presence of a systolic murmur will not influence treatment or prognosis; if a man has infective endocarditis, it does not much matter whether his mitral valve is competent or not; again in the graver types of organic heart disease, such as mitral stenosis with auricular fibrillation, the correct interpretation of any systolic murmur that may be present is not of great moment. The type of case in which its true significance must be correctly estimated is afforded by the patient who comes to you with a systolic murmur, but with a heart of normal size, and a regular pulse, a radial artery which is not thickened, a normal blood pressure and healthy general appearance, a patient, in short, whose systolic murmur is the only indication of any possible cardiac abnormality.

Before giving an opinion on such a patient's heart it is absolutely essential that you should obtain an idea of its functional capacity. The treatment of heart disease really resolves itself into the prevention of further inflammation and the prevention of failure of compensation; the latter is brought about by subjecting the heart to strains greater than it is capable of bearing. Of these strains the most potent is excessive muscular work, and in the very large majority of cases the heart fails, because it is called upon to provide a circulation of blood in excess of its powers. To ascertain the capacity of a heart to stand muscular work you must find out how the patient reacts to exercise, or in other words you must find his "exercise tolerance." Some idea of this is afforded by the patient's own statements, and taking his history you will inquire what amount of exercise makes him short of breath. I wish, however, to urge you very strongly not to be satisfied simply with the patient's statements on this; shortness of breath is essentially a relative term, and must necessarily be difficult to define exactly, and you will find the widest variations in the opinions of patients as to the point when an increase in the depth and rate of respiration produces the sensation of dyspnœa. It is only by your own observation of the effect of exercise that you can rightly estimate the amount necessary to produce dyspnœa. In a recent volume of the "Guy's Hospital Reports' Professor Pembrey and I describe a method of gauging exercise tolerance, so I will not describe the test we employ in detail; it will suffice to say that it depends on finding the amount of walking exercise required to produce a given effect on the pulse rate. To obtain the same effect on the pulse a greater amount of work is required in the case of the healthy man than in the case of a man with heart disease, and the difference between these two amounts measures the relative efficiencies of the two men.

Having decided whether a murmur is functional or not, and having gauged the patient's exercise tolerance we are in a position to estimate the significance of the murmur. The murmurs will vary in significance according to their nature, and it is convenient to consider them under the following groups: (1) Functional murmurs, mitral and basal; (2) The murmur of aortic stenosis; (3) The murmur of pulmonary stenosis; (4) The murmur due to atheroma of the aorta; (5) The murmur of mitral regurgitation. I would emphasise once more that in all cases I am assuming that there are no other signs of heart disease.

(1) Functional murmurs heard over the mitral area or at the base of the heart.—If the exercise tolerance is good, these murmurs may be entirely disregarded; they do not indicate heart disease, and the man can be passed as a first-class life. If the exercise tolerance is poor, the patient is suffering from what is termed the "Effort Syndrome" or, in the army, "Disordered Action of the Heart," or "D.A.H." This is a condition, in which the patient suffers from dyspnœa, precordial pain and palpitation on exertion, but in which the heart is organically sound, and which does not result in waterlogging and the other signs of serious heart failure. Having diagnosed effort syndrome you will of course look for any possible cause, such as septic absorption from pyorrhœa, or phthisis which may be responsible for it, and the discovery of any such condition will, of course, alter the whole aspect of the case.

In treating such patients there are two things you must do; firstly you must reassure the patient as to the condition of his heart; secondly you must encourage him to take gradually increasing amounts of exercise and so "train" his heart; you will find the results of graduated exercise most satisfactory, for all patients improve materially, and a very large proportion are completely cured. But, perhaps, even greater relief is given to the patient by the assurance that he has not got heart disease, and by the knowledge that he can resume his ordinary habits of life. Many of these patients become so nervous about their hearts, that they drift into a condition of serious cardiac neurasthenia, and every time a slight attack of indigestion makes them conscious of the beating of their heart they fear that their end has come. Many, too, have quite unnecessarily given up their work, (sometimes at great financial inconvenience), or some form of athletics that they greatly enjoyed. Such cases have become very common since the war, for many men were invalided out of the army labelled valvular disease on account of a functional murmur. The other day I saw a man of thirty whose greatest joy in life was hunting; he had been told some eighteen months previously that he had aortic stenosis and must never ride again. He had

a functional murmur, but no sign of heart disease; his exercise tolerance was a little below normal as the result of leading a very sedentary life, but a very short period of training was sufficient to get him fit again, and he now can take any exercise he likes.

(2) The murmur of aortic stenosis.—This really does not fall within the scope of our discussion, as it is practically always associated with aortic regurgitation and cardiac enlargement.

(3) The murmur of pulmonary stenosis.—Slight degrees of pulmonary stenosis may exist with a good exercise tolerance and without any other evidence of congenital heart disease. I have occasionally found this lesion in the course of routine examination in men who had done heavy work without any cardiac symptoms, and who were suffering from something quite unconnected with their hearts. In the more advanced cases with cyanosis, dyspnœa occurs on exertion, and it is necessary to limit their activities.

(4) The murmur due to atheroma of the aorta.—This must always be looked upon as a more or less serious condition, for the murmur only occurs when the atheroma is advanced. If cardiac symptoms are absent a fair amount of freedom in the matter of exercise is permissible, but the more violent forms must be forbidden, because it is certain that with advanced atheroma of the aorta the coronary arteries will not be free from disease, and there is, therefore, a potential cause of myocardial degeneration. In these patients you must pay special attention to the state of the peripheral vessels, the blood pressure and urine. In every case a Wassermann reaction should be done as the disease is so often syphilitic in origin, and I need not emphasise the importance of looking very carefully for signs of an aneurism.

(5) The murmur of mitral regurgitation.—There is more difference of opinion on the importance of this murmur than of any other cardiac sign. It has been pointed out that mitral regurgitation due to rheumatic endocarditis can co-exist with a normal exercise tolerance, and that patients in this condition can often undertake hard physical work and indulge in the more strenuous forms of athletics without any detriment to their health. This is undoubtedly true; I know a man who has had mitral regurgitation for seven years, who is nevertheless able to play any game he wishes, and he is none the worse for it; his heart muscle is sound and perfectly well able to compensate for the valvular defect. On the other hand the reverse may happen, as was shown by the case of a boy of thirteen, who came into Addison about two years ago; he had a comparatively mild attack of acute rheumatism, which slightly damaged his mitral valve. He had prolonged treatment with salicylates, rest and subsequently graduated exercise, and when he left hospital his heart was normal in size, he was able to run about as well as any other child of his age, and the only sign of anything abnormal was a mitral systolic murmur propagated into the axilla. He was back in hospital in ten days with another attack of acute rheumatism of which he died six weeks later. Results as disappointing as this are fortunately not very common, but everyone who has seen medical out-patients for any length of time, is familiar with the patient who leaves hospital with mitral regurgitation, and who, without any signs of a recurrence of rheumatism gradually developes mitral stenosis, a clear indication that the infection we thought was dead was only slumbering. For this reason I cannot view rheumatic mitral regurgitation, particularly in children, without anxiety, however good the exercise tolerance. The danger does not lie so much in the possibility of too much exertion producing cardiac failure—cardiac failure in the form in which we see it in adults, with general waterlogging, is rare in children, apart from an acute myocarditis, so well does the growing heart of the child compensate for any valvular defect—but rather in the liability to a recurrence of the original infection; even if this does not flare up with acute arthritis and obvious involvement of the heart, it is extremely difficult to know when a slow chronic rheumatic inflammation has completely ceased.

In elderly subjects mitral regurgitation due to a relaxed mitral ring is not necessarily a serious sign, but it should not be regarded as of no importance at all. It must mean that the muscle has lost its normal tone, even if this loss is not always due to some degenerative process. It is quite true that we cannot estimate from the murmur alone the degree of damage, and that prognosis and treatment must be guided chiefly by other considerations, such as the degree of incapacity and the cause of the dilatation, but I do not

believe that in any case where we are satisfied that mitral regurgitation exists, we are right in looking upon the condition merely as of academic interest.

You will realise that in this lecture I have touched on many points where there is considerable difference of opinion among physicians. The view once prevalent, but never universal, that every systolic murmur was an indication of heart disease is dead, and rightly so, for its supporters condemned every patient with a murmur, functional or not, to a life of invalidism. The reaction from this view has resulted in opinion in some schools swinging to the other extreme, and here the tendency is to teach that the diagnosis of a functional murmur from an organic murmur is usually impossible, and that in any case a systolic murmur alone tells us nothing of the capacity of the heart to do work, and is therefore of little importance. This teaching has undoubtedly done great service in insisting on treatment being guided largely by a knowledge of cardiac efficiency as learned by some form of exercise test and in all cases of what we may term "chronic heart disease," it is essential to know what amount of exertion the patient can stand without detriment. This view about systolic murmurs is, however, too extreme, and I feel very strongly that we should attempt to differentiate them and to attach to each its proper significance. In this lecture I have tried to indicate to you the principles on which I believe it is possible to do this.

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Neurological Surgery.

DEAR MR. EDITOR,—

The following notes on neurological surgery in America may, perhaps, be of interest to some of your readers.

BRAIN TUMOURS.

The operability of a brain tumour depends upon its size, nature and situation, and these factors are to some extent closely related. The endotheliomas arise in connection with the dura and cranial sinuses and are, therefore ,cortical in situation, at any rate in the earlier stages of their development. It follows that early diagnosis and localisation is generally possible, and as these tumours are encapsulated and do not recur after removal the prognosis is relatively good, while unless deeply situated between the hemispheres or around the base of the brain their removal is not attended by any great difficulty.

The gliomas, although found in any part of the brain, are most commonly subcortical and very often confined to a silent area. Localisation in the majority of cases, excluding those of the cerebellum, is either impossible or possible only when its size precludes removal, for then the necessary wide excision of brain substance leaves the patient after operation in a worse condition than before, and the mortality rate of this procedure is extremely high.

Heuer in a recent review of a considerable number of these cases at the Johns Hopkins Hospital found that in no case in which the removal of the glioma had been attempted had the patient survived the operation for more than four years, while in those cases with the most extensive tumours treated by decompression alone, life was often prolonged for eight, nine and ten years.

In view of this comparison, the radical removal of gliomas of any considerable size has been abandoned in favour of palliative decompression and radium, and the only hope of successfully treating such cases in the future as far as surgery is concerned lies in early and accurate diagnosis.

In the same series of cases it was found that 85 per cent. of all verified tumours were gliomata, (70 per cent. solid tumours, and 15 per cent. gliomatous cysts). In the case of these cysts the prognosis is rather better than that of the solid tumours, and treatment of the cyst wall with Kaiserlings' fluid has been found satisfactory, although in many cases the cyst refills and periodic evacuation of its contents is the only possible treatment.

According to Dandy localisation of a cerebral tumour by neurological means is only possible in about 50 per cent. of cases, and with a view to localising the remainder, most of which are subcortical, he has introduced ventriculography.

By this method the ventricles are emptied of their cerebrospinal fluid, which is replaced by air, and the head is X-rayed. In the radiogram any change in size, shape or position of the normal ventricular outline is carefully noted. To produce such a change it seems clear that in most cases the tumour must have started its growth in close proximity to the wall of the ventricle, a not very common occurrence, or if midway between the ventricular wall and cortex must have reached a size too large for removal. The technique is simple, but in the hands of others the method has not been so successful as in those of its originator.

Fatalities have occurred, and for this reason the method has been abandoned by most neurologists who prefer, at any rate for the present, to leave it in the hands of its sponsor.

In distinguishing lesions above, from those below the tentorium cerebelli, the method has proved of considerable value, for, in a critical case of doubtful diagnosis, a subtemporal decompression will only subject a patient with a cerebellar lesion to the risk of an operation without any possible improvement, as will a cerebellar decompression in the case of a cerebral lesion. For those tumours lying above the tentorium, in the silent area of the occipital lobe, and producing an obstructive hydrocephalus, ventriculography may be the only way of arriving at a correct diagnosis. The distension and deformity of the ventricle in these cases is diagnostic. In the obstructive type of hydrocephalus the method will immediately localise the obstruction: in a recent case of this kind I saw the surgeon split the corpus callosum and remove from the third ventricle a small ependymal tumour, obstructing the foramen of Monro and producing a unilateral hydrocephalus accurately diagnosed by ventriculography.

Diagnostic puncture of the cisterna magna advocated by Ayer is, like ventriculography, in its experimental stage. The proximity of the tip of the needle to the fourth ventricle may not be without serious consequences. Cushing emphasises the risk of sudden respiratory failure following lumbar puncture for diagnosis in cases of suspected brain tumour, and the procedure is never used in his clinic under these circumstances.

If the tumour has been localised, an osteoplastic flap is turned down over the selected area. Cushing insists that large areas of the calvarium should never be sacrificed in eradicating tumours, adding that "it is highly desirable that the cranial chamber should be kept as intact as one's skill and conditions permit."

When extirpation is anticipated the operation is preferably conducted in one session, and two-stage operations are less frequently performed unless the surgeon is embarrassed by excessive hæmorrhage in elevating the flap, when the same difficulty will be encountered on attempting to remove the tumour. Having decided to postpone the removal of the tumour until a more favourable occasion, it is usual to open the dura in the lower part of the temporal region and puncture the ventricle. It not infrequently happens that following the fall in the intracranial pressure, the hæmorrhage becomes less troublesome, allowing the surgeon to continue.

If the dura is widely opened and the intracranial pressure high, the protrusion of the brain will make replacement of the bone flap very difficult or impossible, and it may be necessary to strip off the bone from the flap, a proceeding which leaves an unnecessarily large cranial defect, or proceed with the enucleation of the tumour in spite of the condition of the patient.

If the tumour is not discovered or found to be irremovable, the base of the bone flap is broken off provided that this lies beneath the temporal muscle. The remainder of the flap is replaced and the patient is left with a subtemporal decompression. The bone is not removed above the origin of the temporal muscle.

Early subtemporal decompression is always performed as soon as the diagnosis of increased intracranial pressure is made. If hydrocephalus is the cause of this condition, decompression will be of very little value, but the diagnosis can be determined by ventricular puncture at the time of operation.

Early decompression is most valuable in those cases where the tumour has not been localised, and is strongly advocated by Cushing when the surgeon is waiting for the appearance of focal signs. Many, however, prefer an exploratory osteoplastic operation in the first instance, provided there is some indication as to the side affected, while if nothing is discovered, the base of the bone flap may be removed and the patient left with a decompression

In the presence of a questionable cerebellar lesion when the symptoms hardly justify the elaborate and difficult suboccipital exposure, a subtemporal decompression may be performed for diagnosis, provided there is no extreme urgency.

In the case of a cerebellar tumour the operation is the same whether it resolves into a decompression, or a partial or complete removal of the tumour. The exposure is always bilateral, allowing an examination of each lateral recess.

Cerebral Trauma.

In discussing the indication for operative interference in traumatic cases, Frazier emphasises the

fact that an increasing blood pressure is by no means an infallible operative sign. In his opinion the pulse pressure is more important, "for, as the pulse pressure approaches the pulse rate, the time for interference is at hand."

Lumbar puncture is helpful, and it is not generally necessary to use a manometer, as has been suggested to diagnose an increased pressure.

In the group of border-line cases of compression generally treated by conservative means, Cushing is of the opinion that less risk is run by prompt exploration, and decompression than by waiting for nature to take its course, in absorbing œdema and extravasation in an unopened skull.

In his experience decompression appears to lessen the many unpleasant late sequelæ of cerebral injuries, including the traumatic neuroses so often a feature of those cases which recover without operation. In such cases approach to the skull through the temporal muscle has the following advantages—

1. The approach is through the thinnest part of the skull.

2. The muscle when sutured prevents excessive bulging, or excessive retraction when the intracranial conditions become normal, while the subsequent defect is harmless.

3. In case of an extradural hæmorrhage the clot is at once exposed, and ligature of the middle meningeal artery is not difficult.

4. Free bleeding from the base can be best treated by protective drains placed under the temporal lobes.

A few details of Cushing's technique may be of interest. A straight incision, parallel to the fibres of the temporal muscle, is made just in front of the ear, and the fibres of the muscle retracted, care being taken not to detach it from its origin. The fingers of the assistants control the hæmorrhage by pressure on the edges of the wound, until forceps are applied to the galea, which is then turned over. With the exception of the superficial temporal artery no ligatures are needed for the vessels of the scalp on completing the operation.

Any hæmorrhage from the dura is controlled by the application of silver clips, and the wound sutured in four layers with interrupted stitches of fine silk. Cushing lays great stress on the necessity of careful, and painstaking, closure of the wound. "Imperfections in technique in operations in other parts of the body, when tissues other than those of the central nervous system are involved, may delay recovery, but do not necessarily impair an end result, but corresponding slips, which compromise the future of the nervous system, may sometimes leave mental and other disturbances to which death is preferable."

There are two lesions which, in view of the progress made in their diagnosis, and treatment, are entitled to more detailed consideration—

1. The chiasmal lesions.
2. The acoustic neuromas.

1. *Chiasmal Lesions.*—This term is used in its broadest sense to include those tumours in and around the optic chiasma and include the hypophyseal cysts and tumours, the primary chiasmal tumours, and the suprasellar cysts and tumours. In this group the hypophyseal lesions are by far the most common. Regarding the frequency of the suprasellar lesions there is some difference of opinion and some think that they are much more common than is generally supposed. Differentiation on clinical grounds may be very difficult or impossible, but a correct diagnosis is of the highest importance in considering the treatment and method of approach.

Hypophyseal Tumours.—In a series of cases at the Johns Hopkins' Hospital, all the hypophyseal tumours were found to be adenomas, and the greater number of these—about 80 per cent.—were solid. All the cysts in this series had adenomatous tissue in their walls, and this supports the general impression that primary cysts of the pituitary body are rare.

In the early period of their growth pituitary tumours are confined to the sella tursica, but sooner or later extend beyond its confines, and the direction of growth is a matter of much importance, for upon this depends the choice of operation. It has been generally supposed, on account of the thinning of the floor of the sella, and its occasional absence, that the spread of the tumour is primarily downwards. Heuer, on the other hand, has recently advanced and substantiated the view that these tumours expand in an upward direction before the floor of the sella becomes involved, and therefore advises approach from above. If this view is correct, a sellar decompression, at present the operation of choice in such cases, cannot prevent further intracranial involvement if this has already occurred, while it is impossible to deal with the part of the growth above the diaphragmar sellar by this method of approach.

The trans-sphenoidal operation is admittedly more septic than the transfrontal or lateral operation, while, should the tumour recur or continue, the trans-sphenoidal approach is not one that is likely to be repeated with equal success, and the intracranial approach becomes imperative. Heuer's views on this subject, however, are by no means generally accepted, and regarding the direction of growth in these tumours further observations are necessary before the matter can be settled. At present the mortality of the intracranial operation is very much

higher than that of the trans-sphenoidal operation, while in the latter convalescence is uneventful, recovery of vision is usually rapid, this being at present the criterion of a successful procedure.

In the case of a hypophyseal tumour surmounting an intact sella of normal proportions, the trans-sphenoidal route has not to be considered, and the tumour must be approached either by the transfrontal route (Cushing) or by the lateral route (Frazier), a large and adequate bone flap being turned down in either case.

Of the suprasellar lesions, a great number are cysts arising in connection with the cranio-pharyngeal duct. Their treatment has hitherto been very unsatisfactory, and in most instances the operation is followed by a recurrence.

2. *Acoustic Neuromas.*—In these tumours diagnosis and treatment have attained greater perfection than in the case of any other intracranial tumour with, perhaps, the exception of the pituitary adenomas and the Gasserian endotheliomas which, although rare, "are pressing for first place in certainty of diagnosis and precision of treatment." (Cushing). The acoustic neuromas at present account for nearly 10 per cent. of all verified tumours, 60 per cent. of all extra-cerebellar lesions, and by far and away the majority of those involving the cerebello-pontine angle.

These tumours arise from the portion of the eighth nerve adjoining the porus acousticus internus where the non-medullated fibres of the nerve become medullated and the glial supporting substance becomes connective tissue. As the growth enlarges, the patient complains of tinnitus followed by progressive deafness. Cushing in the diagnosis of these lesions emphasises the fact that long-standing deafness in one ear is the most vital and important point.

As the tumour enlarges, the eighth nerve becomes gradually destroyed, while pressure on the adjoining seventh nerve not infrequently causes a facial paralysis. The other cranial nerves become involved at a later stage, and finally pressure on the cerebellum results in nystagmus and inco-ordination, while occlusion of aqueduct of Sylvius leads to an obstructive hydrocephalus.

Total extirpation of these tumours on account of the very high mortality is never feasible, unless the tumour is small, which is unlikely, or confined to the nerve in the region of the internal auditory meatus. In this case excision is possible, since damage to the medulla may be avoided. It is usual to incise the capsule of the tumour, and remove as much of its contents as possible, realising, of course, that this measure is only palliative and its repetition may be subsequently necessary. When the tumour is largely fibrous, it may be possible to remove only a small part and the beneficial results of the operation are largely due to the wide cerebellar decompression. In general the thoroughness with which the contents of an acoustic neuroma can be removed depends upon the softness of the growth and the degree of fatty infiltration which it has undergone.

Hydrocephalus.

Until recently hydrocephalus was considered an idiopathic condition for which no successful treatment either medical or surgical had been found. Recently, however, the researches of Dandy and Blackfan on the cerebro-spinal circulation have led to a better understanding of its pathology and, in turn, to the employment of rational treatment.

The vast majority of cases fall into two groups—(1) the obstructive, and (2) the communicating, while the older classification, into internal and external hydrocephalus, has been discarded, since external hydrocephalus is probably never a primary condition, but rather a late result of internal hydrocephalus. In the obstructive type the cerebrospinal fluid formed in the ventricle cannot reach the exterior, while in the communicating type it only reaches a small part of the external absorbing surface, the cisterna magna, and the spinal cord. In both these types there is a diminished absorption of cerebrospinal fluid, and although acute hydrocephalus may result from an increased production of fluid in acute meningitis, or trauma, this condition is rare.

It follows, then, that the two chief types of hydrocephalus, communicating and obstructive, have fundamentally the same pathology, and the only reason for their differentiation lies in the fact that the treatment of one differs entirely from that of the other. This being so, it becomes essential in considering the treatment of a case to find out to which group it belongs, and this is done by the phenolsulphenolphthalein test. This substance is injected into the lower part of the spinal theca in the usual way and after an interval of five to ten minutes the ventricle is tapped and some of its contents removed. Should this contain the phthalein the obstructive clearly lies in the subarachnoid space and the hydrocephalus is a communicating one, while, should it not, the hydrocephalus is of the obstructive type, the obstruction being generally in the aqueduct of Sylvius, occasionally at the foramina of Majendie and Luschka and very rarely at the foramen of Monro. In adults occlusion of the foramina of the fourth ventricle gives rise to symptoms suggesting a cerebellar lesion, and the neurologist, not suspecting a hydrocephalus, may not apply this test.

In those cases of hydrocephalus due to obstruction of the aqueduct of Sylvius, Dandy has attempted to remove the obstruction by passing a catheter along the aqueduct, and leaving it in situ for a short time. This procedure did not, however, prove successful, for, as soon as the catheter was removed, the ob-

struction recurred. He now practises removal of the floor of the third ventricle in these cases, and although the approach is difficult, and necessitates division of the infundibulum, and occasionally one of the optic nerves, the results promise to be more satisfactory.

In two cases, where the foramina in the roof of the fourth ventricle have become occluded in adults, Dandy was able to reconstitute an opening with complete success.

In hydrocephalus of the communicating type attempts have been made to remove the choroid plexus, since obliteration of the whole subarachnoid space prevents any possible absorption of the cerebro-spinal fluid. This is naturally a severe operation, and there have been no recoveries in the few cases in which it has been performed.

Although most of the above attempts to deal with these conditions have not been very successful, they mark a new era in the treatment of hydrocephalus. Hitherto the surgeon has attempted to drain the fluid into the tissue spaces of the body, a procedure always unsuccessful, since by some property of extracranial tissues, these spaces soon become lined by an endothelium impervious to the escape of the fluid.

Alteration in the intracranial tension following the administration of hypertonic saline.—Weed and MacKibben have shown that it is possible to reduce the cerebro-spinal pressure and diminish the bulk of the brain by injecting a hypertonic solution of saline into the blood stream.

It not infrequently happens in the later stages of a cerebral exploration, or decompression, that the surgeon experiences great difficulty in closing his wound, owing to the protrusion of the brain, and hypertonic saline given intravenously under these circumstances will within a few minutes overcome this difficulty, and allow a satisfactory closure.

Cushing and Foley, fearing that intravenous hypertonic saline was probably accompanied by some risk, produced similar results with hypertonic solutions in the alimentary canal which were not attended by any change in the blood pressure, pulse or respiration. It seems possible that this method might be tried with success in traumatic cases, with slight symptoms of compression, due to cerebral œdema.

Trigeminal Neuralgia.—Regarding the pathology of this condition nothing is known. Presumably it is an affection of the ganglion, although repeated examination of those removed at operation has revealed no demonstrable change.

The treatment of trigeminal neuralgia by division of the posterior root of the Gasserian ganglion is one of the most satisfactory operations in surgery, and in those cases in which it has failed the diagnosis has always been incorrect. Several conditions resemble the major form of doulereux to which Cushing has recently drawn attention, among them being the neuralgias attributed to Meckel's ganglion. Sluder originally described this condition and believed that it was due to an inflammatory process in the air sinuses involving the ganglion where the bony partition separating them from the sphenopalatine fossa was either extremely thin or absent.

In these cases the pain is usually deep-seated, as opposed to the superficial character of that of trigeminal neuralgia, frequently most intense at a point about an inch behind the lateral orbital margin, sometimes radiating to the mastoid region and passing down the neck, and is not uncommonly bilateral. In trigeminal neuralgia it is usual to doubt the diagnosis, if the patient is under 40, while in this type of neuralgia the patients are generally young. I recently had the opportunity of seeing Frazier demonstrate a case of Sluder's neuralgia in which the patient—a young woman—complained of intense pain in the face for which a Gasserian neurectomy had been done without the slightest relief. She was brought into the operating theatre, in great agony, and a few minutes after the application of 10 per cent. cocaine to the mucous membrane under the middle turbinate, the patient left with complete relief.

In trigeminal neuralgia, affecting one or two branches of the nerve, it is usual to treat the condition by deep injections of alcohol, and peripheral neurectomies have been generally abandoned except in the case of the supraorbital nerve where injection is impossible as the alcohol occasionally finds its way into the orbit with disastrous results.

Cushing advocates alcoholic injections in every case, as a preliminary measure, for although in his experience its results are never permanent, it is of great value in confirming the diagnosis, and should operation be later decided upon, the patient will to some extent have become accustomed to the ensuing numbness of the face. The relief afforded by such injections may at first last for several months, but this period generally becomes less and less, until the treatment ceases to give any relief, and operation becomes necessary.

Attempted injection of the ganglion itself has long been discontinued by Cushing and others, owing to its frequent complications. The alcohol may find its way into the posterior cranial fossa, producing various oculomotor palsies, headache, vomiting, ataxia and collapse, while the results of this method are very little better than those of deep extracranial injections, and its complications more serious.

Division of the posterior root of the Gasserian Ganglion.—Of the various methods at present in use that of Adson, of the Mayo Clinic, is the most simple. Extirpation of the ganglion is unnecessary, and is no longer performed. A vertical incision is made parallel to the fibre of the temporal muscle,

having its lower extremity at the zygoma. The fibres of the muscle are retracted, and a low trephine opening made in the squamous portion of the temporal bone. This should be made as low as possible, so that the operator reaches the floor of the middle fossa, without having unduly to elevate the temporal lobe. The dura is pushed back by careful sponging, and the middle meningeal artery emerging from the foramen spinosum soon comes into view. If it is impossible to tie this vessel with fine silk, or if its situation will not allow the application of Cushing's silver clips, the foramen spinosum is usually plugged with wax. Sometimes the spurs of bone on the floor of the middle fossa occlude the view of the operator, and it is necessary to remove them. The reflection of the dura is continued until the pulsations of Meckel's cave are seen, and the upper layer of its dura is then divided. This is followed by the escape of cerebro-spinal fluid, and on continuing the incision backwards, for a short distance, the posterior root of the ganglion is displayed. Adson cuts this with a guillotine knife, and turns back the posterior end, while Cushing prefers avulsion. Frazier has recently modified his technique, and attempts to save the underlying motor root by separating it, if possible, and identifying it with an electrode. Whether this is a desirable step, or not, is a matter of dispute. It is not certain that the motor branch does not contain sensory fibres. while, if the temporal fascia and galea are carefully sutured, the deformity of the temporal region will be little or none. Careful hæmostasis is essential, and the wound is closed in layers by interrupted stitches of fine silk, without drainage.

A temporary facial paralysis is a complication of this operation that has not yet been satisfactorily explained, but this passes off in the course of a few days. Cushing's patients have the eye covered until the wound has healed. The lids are never sewn together, and eye complications are uncommon. Adson, in a large number of cases, had a mortality of one-half per cent., while Cushing has not had a death in 500 consecutive cases.—I am, Sir, yours, etc.,

GRANT MASSIE.

The Mayo Clinic,
Rochester, Minn.
November, 1921.

Operation for Relapsing Appendicitis.

DEAR MR. EDITOR,—Allow me to add a few remarks to your account of the above in your last issue. I am proud that the conception arose in our Hospital.

It was Dr. Carrington who first asked me to see the case with a view to operation. We concluded that the mass to be felt would probably be absorbed. On Dr. Mahomed's resuming duty after his holiday he pointed out that as the man had had twenty-six attacks and in consequence had been unable to retain a post for any length of time, something should be done. I was merely the instrument.

This case led me to study the morbid anatomy of appendicitis as exhibited in the post-mortem records compiled by Wilks and Moxon. Here one found the whole of the morbid anatomy described with admirable sketches of the appendix in all stages of disease showing the usual concretions, perforations, gangrene, etc.

While I was so employed one day, Mahomed rushed in and exclaimed, "I have been hunting for you everywhere and here you are consulting these old records and if you go on like this you will become like B— and not give a final opinion on anything. I have a case of intestinal obstruction and I want you to operate at once." Going with him to the bedside I agreed to the operation, but insisted on a right-sided incision, convinced from the very investigations he had interrupted, that the case was one of acute appendicitis with general peritonitis; and so it proved.

Later observations proved that a calcareous concretion never lies within the appendix, as was supposed in the original case. The fæcal concretion escapes through a perforation in an acute attack, the canal is closed before or after, and then the calcareous salts are deposited. I have several specimens of such, one being a pin surrounded by a crystalline formation, removed by a free opening of the peritoneum, so that the whole anatomy could be studied and the truth of the observation established.

The progress of surgery is more indebted to the foresight of our physicians than many are disposed to allow. The first removal of a renal calculus was undertaken at the Middlesex Hospital by Sir Henry Morris at the suggestion of Dr. Sydney Coupland, and at Guy's it was again Dr. Mahomed who secured the first at Guy's. And was it not at Dr. Habershon's suggestion that Cooper Foster was the first to remove a foreign body from the stomach?—Faithfully yours,

CHARTERS SYMONDS.

P.S.—I showed the calculus to Dr. Hilton Fagge, who was at that time suffering from the malady of which he died, and was confined to the house. "Yes," he replied, "it is very interesting, but I don't suppose it will be done again."

The Operative Treatment of Appendicitis.

DEAR SIR,—Your article in the GAZETTE for 12th November in which you remind us that Sir Charters Symonds performed the first internal operation for appendicitis, prompts me to bring to the recollection of your readers that this disease was first described by Bright and Addison. Their descriptions, said by Kelly from whom you quote, to be "so clear and well presented that they could not be surpassed to-

day," will be found in "Elements of the Practice of Medicine," by Richard Bright, M.D., and Thomas Addison, M.D., London, 1839, vol. I., p. 498. They are reprinted in the "Guy's Hospital Reports," vol. 71, No. 2, April, 1921.

It appears, therefore, that both the description and modern treatment of this disease had their origin in the School of this Hospital.—Yours sincerely,

38, Wimpole Street, W. HALE-WHITE.
W. 1.
14th November, 1921.

Guy's 1920-21 Rugby Record.

DEAR SIR,—I have received the Clubs' Year Book 1921—22. In looking through last season's "Rugger" results 1st XV., I find the following figures are quoted—602 For; 96 Against. Being an ardent follower of the "Rugger" team, and having kept press cuttings and various statistics of all the matches, I find (if I am correct) two mistakes in the table quoted. In the first match v. Catford Bridge, 25th September, the score given is 44—nil, whereas, I believe the result was 39—nil; score as follows:—Tries, Krige 1, Van der Post 2, Graham-Davies 2, Watson 2, Steyn 2, Bekker 2, and Van Schalkwijk 3 goals.

The second instance is v. Gloucester at Gloucester, October 16th, the score given is 0—6, whereas my record gives the score as 3—6. "Dix was penalised in the last few minutes and Van Schalkwijk dropped a fine goal." This gives the final total scores as 600 For, 96 Against. A remarkably fine record, which, I trust, this season's result will be near.

The average for last season's matches worked out at—Average points per match, For, 22·2; Against, 3·5.

Up-to-date, it is pleasing to note that Guy's lead the way in Club "Rugger" results; taking 2 points for a win and 1 for a draw, Guy's percentage is 87.50, followed by Bath, Blackheath, Cross Keys and Pontypool bracketed together with 83·33.

Trusting these figures will be of interest to you,—I am, yours truly, ROY C. HOLLOWAY.

100, Elliscombe Road,
Old Charlton, S.E. 7.
17th November, 1921.

THE EDITOR will, at all times, be glad to consider articles or sketches, provided that they are accompanied by the writer's name and address, not necessarily for publication. The payment that the GAZETTE *can offer is merely nominal. Authors who desire reprints of their papers should make their own arrangements with the printers when they return their proofs. All contributions to be addressed to the Editor, "Guy's Hospital Gazette," Guy's Hospital, London, S.E.*

Reviews.

Training, and how to keep always fit. By Charles W. Cathcart, C.B.E., M.A., M.B. Edin., F.R.C.S. (Messrs. E. & S. Livingstone.)

These interesting articles were originally published in "The Student," and are now issued as a small volume in the hope, as the author's preface states, "not only that those who run may read, but that even more who read may run." The author's enthusiasm is certainly likely to be communicated to his readers, and the excellent advice set forth in these pages will prove of value to many athletes.

An attempt is made in this volume to adapt the more or less empirical systems of old-time trainers and coaches to the principles of modern physiology. With Chapter I., on Exercise and Breathing, we are in cordial agreement, and Chapter II., on Fresh Air, is admirable. In Chapter III., which deals with Food, the author quotes the experiments of Chittenden on Diet, and adopts his conclusions. While the experimental evidence that an individual may maintain his health and endurance on a low protein diet, by means of slow mastication and other measures, seems to be perfect, we cannot bring ourselves to accept so low a dietetic scale as Chittenden's as being the best possible for the average athlete. Let us avoid over-indulgence in food by all means. But we cannot endorse the author's plea for a restriction of diet. The opinion of physiologists is in favour of a daily protein intake of at least 80 grammes, and the experience of the war has shown us that a nation cannot cut down its diet, as Germany did, to two-thirds (or less) of the normal, without suffering considerably in stamina and resistance to infection.

The remaining chapters deal with alcohol, tobacco, and economy of nerve energy. As regards tobacco, its use in moderation does not seem to impair seriously the efficiency of, say, a Rugger forward. To be frankly hedonistic, we sympathise with the man who likes his pipe, and doubt if he does himself serious harm by its use. During strict training, of course, it is wise to refrain from smoking. Whatever one's personal views, however, one cannot fail to appreciate the author's enthusiasm and the value of the evidence he has so ably summarised. One's interest is maintained throughout. Every athlete should read, mark, learn and inwardly digest these articles.

Local Anæsthesia in Dental Surgery. By Norman Black, L.D.S.Eng. (Messrs. John Bale, Sons, and Daniellson. 1921.) Price 5s. net.

This small book gives in a very clear and concise form the various methods used to obtain local anæsthesia in dentistry. The older methods are touched upon. Local infiltration and submucous anæsthesia

are briefly described, but the bulk of the volume is given up to the anatomy of, and operative technique for, paralysing the second and third divisions of the fifth cranial nerve. This is extremely well described, but the illustrations are not as clear as they might be.

Nerve blocking, as it is called, cannot eliminate completely the use of general anæsthetics, as is stated on p. 35. In the case of the common conditions of forced closure of the jaw, due to suppurations arising from a lower third molar, a general anæsthetic is the only practicable one for several reasons. Muscular spasm must be overcome and the acute generalised oral sepsis strongly contraindicates any injection method. The advantages of weak solution of cocaine hydrochloride are strongly insisted upon, but the student would be wise in remembering that the synthetic anæsthetics are far less toxic; and that, although anæsthesia takes longer to produce, they are safer. Pressure anæsthesia and intrafœotan injection, which latter is not commonly used, together with a chapter on the toxic symptoms which may arise, complete this very useful little work.

Operative Dental Surgery. By Thomas Goodhugh. 1921. (Published by Baillière, Tindall & Cox.) Price, 18s.

A hurried glance through this book leads one to think from the excellence of some of its illustrations, that a book of no little merit has come to hand. But upon further examination one is disappointed, for the author flounders about in a wealth of superfluous detail on physiology, anatomy, physics,—and detail of so elementary a character that one becomes bored, and discards the book with a sigh of disappointment —— for the diagrams, after all, were remarkably good !

Notes on Dental Surgery and Pathology. By T. W. Widdowson, L.D.S. Second Edition, 1921. (Published by John Bale & Sons & Danielsson, Ltd.) Price 21s. net.

As the title would indicate to one, this book is meant to be of a concise and tabulated form, with the object of providing the student with a "cram-book" and the practitioner with a ready reference guide.

Unfortunately it is of rather bulky size, and, as a note-book, would appear to be unwieldy. Its bulkiness is due no doubt to the marginal space which has been left for the readers' own notes on the subject. Yet the essential feature of a note-book is surely its compactness and portability—but that is a matter for the reader to decide.

Chapter II., on "The care of the deciduous teeth," should be considerably condensed, and not be given up to needless homilies on the public duties of a dentist.

A Pocket Surgery. By Duncan C. L. Fitzwilliams, C M.G., M.D., Ch.M., F.R.C.S. (Edin. and Eng.). (Messrs. Edward Arnold & Co., 1921.) 10s. 6d.

In the preface to this volume the author states that he has attempted to confine the whole range of examination surgery within a very small compass. That the compass is smal is true—there are 342 pages of quite readable print—but that the whole range of examination surgery has been covered is perhaps a matter of opinion.

Given sufficient hospital experience, and a ful course of surgical lectures, it is quite possible, though very risky, to take any of the qualifying exams. without any reading at all, and, in this case, the whole range of examination surgery might be written on the back of a postage stamp. Nevertheless, we agree with the author that most surgery books are altogether too bulky for systematic reading before an exam., and that many students will find in the "Pocket Surgery" a book admirably suited to their needs. Students at any big hospital who have the advantage of attending the out-patient departments, of going round with clinical registrars, and listening to lectures by specialists in the multifarious branches of surgery, will be amongst those to whom the "Pocket Surgery" will come as friend in need during that trying "last three months" before the final.

We congratulate the author on a very humanitarian achievement.

Materia Medica and Therapeutics. By J. M. Bruce and W. J. Dilling. 12th Edition, revised. (Cassell & Co.) Price 10s. 6d.

This deservedly popular book has now reached its twelfth edition, and the authors have thoroughly revised the work, bringing it into line with modern pharmacological research. The arrangement of the previous volume has, on the whole, been retained, but two new sections have been added, and many new subjects introduced. The latter include Vitamines, or Accessory Food Factors in Deficiency Diseases, Detoxicated Vaccines and Delayed Chloroform Poisoning.

The new sections deal with Natural Mineral Waters and Baths, and with the often neglected subject of Invalid Diet. The latter especially should be found very useful.

An epitome of the chief regulations of the Dangerous Drugs Act (16th August, 1920) is given at the end of the book.

It is a sad, but not unrecognised fact, that the majority of students who take an examination in Pharmacology concurrently with their Anatomy and Physiology, neglect the former until too late, and get through, if they do, by cramming.

Most men have to learn their therapeutics over again, while in the wards, and they could not do better than read Part III of this work. It deals with General Therapeutics. The subjects are arranged, not by a classification of drugs, but by considering each system

of the body in turn—its physiological, pharmacological and pathological relations, the question of spontaneous recovery, and therapeutics.

The volume is a small one, but the matter it contains is considerable, there being 650 pages of rather small print.

We have no hesitation in recommending the book. It justifies its claim to be "a rational guide to the student and practitioner of medicine in the treatment of disease."

Mind and Its Disorders. 4th Edition. By W. H. B. Stoddart, M.D., F.R.C.P. (H. K. Lucas & Co., Ltd.) 22s. 6d. net.

This book commences with a brief survey of the modern views on psychology, followed by a section dealing with the psychology of the insane, and lastly by a description of the clinical varieties of mental disorder. In general the work is of value in that it provides sufficient information on the functions of the normal mind to enable a reader, unversed in psychology, to form a tolerably clear conception of the processes underlying insanity.

The chapter dealing with the emotions is particularly worthy of study, the author adopting the view that it is the motor expression which gives rise to the emotional tone which is consequently excessive in diseases such as dementia paralytica. Thus, when the nervous system undergoes dissolution, it does so in the reverse order to evolution; the necessary early involvement of the pyramidal tract results in diversion of motor impulses to those primitive motor tracts which normally subserve the function of emotional reaction, this being, therefore, readily evoked.

In the preface the reader is warned that the author is a loyal disciple of Freud, yet this eminent professor, even in the height of enthusiasm, never carried his views to the degree presented in the work under consideration.

For example, the "fæces complex" is quoted as an instance of sublimation. Beginning with reference to the interest of babies in their own excrement the writer states that this is subsequently sublimated into an interest in money, whence are described the expressions "*deposit* account," "*filthy* lucre," an individual "*sticks* to his wealth," etc. Furthermore, we are informed that constipated people are always anxious respecting the expenditure of money, and it is even stated that the term "piles" as used for hæmorrhoids is another suggestive expression!

Having read statements such as these, it occasioned no surprise to learn that alcoholism is usually traceable to repressed homosexuality, or that medical psychologists discern something of the nature of an orgasm when the infant flushes and sinks back from the breast.

On the other hand, the psycho-analyst's view of the etiology of exophthalmic goitre, which is here classed with the anxiety neurosis, is well worthy of perusal. The symptoms are presumed to be due to an expression of repressed fear associated with a repressed, unpleasant incident of sexual nature. This theory has been substantiated by many observers who have found psycho analysis to be of considerable therapeutic value,

Lastly, the Author's statements with reference to the treatment of general paralysis, are open to criticism. He points out that ordinary anti-syphilitic treatment is of no avail because the drugs cannot pass the barrier of the choroid plexus to reach the cerebro-spinal fluid.

Considering that the spirochates lie in the brain substance in this affection the objection is not valid. It is, moreover, difficult to grasp the pharmacological principle whereby hexamine is given with acid sodium phosphate in order to produce a 1 : 20,000 solution of formalin in the cerebro-spinal fluid, in which strength it is held to kill those micro-organisms, other than spirochætes, which are usually present in cerebral syphilis! Furthermore, the writer actually advocates the use of alcohol in such cases because it passes through the dreaded barrier of the choroid plexus.

The work as a whole is good but much has been detracted from its value by the expression of extreme views not borne out by clinical evidence. Presumably this unfortunate attitude comes as a natural reaction to the unjustifiable statements of the anti-Freudian school whose disciples, through lack of experience, or from inherent intellectual inertia, utterly fail to realise the immense advance in mental therapeutics rendered possible by Freud's brilliant researches into the subconscious.

Football.

GUY'S v. CAMBRIDGE UNIVERSITY.

This match was played at Cambridge on Wednesday, November 9th, on a hard ground. G. S. Conway, the Light Blue and International, was not playing for the Varsity, otherwise they were well represented. For the Hospital Graham-Davies and Shelswell could not make the journey. Doherty had the bad luck to miss the train so Guy's took the field 15 minutes late, the Varsity having courteously deferred the start, thinking the Guy's Captain might turn up. The start was not exactly encouraging so far as Guy's were concerned, as Gardiner, the opposing half-back, got over our line within a few minutes of the start. Before 15 minutes had gone by, Illingworth swung the ball wide to Saxon who put in a good run and scored. Now came Guy's turn. Hirschberg, picking up smartly and getting clear, evaded Chapman and got over wide of the posts, and Neser with a very fine kick landed the ball over the bar. Wakefield, the International forward, received the ball after numerous short passes and our line was thus crossed for the third time. As none of these tries had been converted, Cambridge were 9 points up to our 5 when a penalty was

awarded Guy's. From a difficult position Neser again kicked a grand goal. We were thus but one point to the bad at half-time.

On resuming, Doherty took the field, and the seven forwards who, before half-time, had been fast wearing down the Varsity eight, took on a new lease of life. They played a better game than this season has so far seen. Getting into an advantageous spot the ball came to Albertijn who gained a try. Next Neser got over so near the corner flag that one hesitated before one was certain that a try would be awarded. This try Neser goaled. If his previous efforts deserve warm praise, this effort deserved something more. In the last few minutes of the game Wakefield, who seemed always on the ball, got over with another try, our lead being reduced to the final score of 3 goals (1 penalty) 1 try, 16 points, to 4 tries, 12 points.

It was a great win, and the XV. are to be heartily congratulated on it. All played well, but a little extra credit should go to E. J. Crisp for his cool and steady play, to A. Hirschberg who played his best game so far, to F. Bekker for once again proving that he has few better men at the scrum base in in the country, and to E. E. Neser for his goal-kicking.

Guy's Team.—E. J. Crisp, A. Hirschberg, P. K. Albertijn, J. G. Van Schalkwijk, C. L. Steyn, F. Bekker, E. L. Sprong, W. D. Doherty, R. F. H. Duncan, E. E. Neser, W. H. Taylor, G. Zondagh, P. G. Harvey, E. H. Fouraker, L. K. Watson.

GUY'S v. COVENTRY.

When Bristol visited the Hospital ground a month ago, their char-a-banc driver took the wrong turning. The Coventry men on their visit got to London Bridge Station alright, but half of the team caught the train and the other half were left behind. A late start was thus made with this match. The afternoon was very dull, cold and foggy; still, for all that, quite a good crowd gathered by 3 o'clock, and the numbers who came late were more than usual. Possibly this was because Blackheath had scratched their match.

Our ground was hard, but quite playable. R. F. H. Duncan could not play; A. H. Shelswell filled his place. Almost from the kick off our forwards took charge of the game, and the excellent work in the scrum of G. Zondagh, helped by good shoving, kept F. Bekker very busy at the scrum base. The three's had some excellent chances, but for a time the forward pass stopped many a promising run. Coventry were also tackling well. Occasionally A. Elton, the Coventry scrum half, got possession from his side, but did not let the ball out enough. Bekker was, on the other hand, giving Sprong constant passes. From one pass P. K. Albertijn got going from half way. Side-stepping and gaining pace every yard, he sold the dummy twice in quite a short distance and scored a magnificent try. J. G. Van Schalkwijk converted. E. L. Sprong got the next try. The fog had thickened somewhat, but A. Hirschberg, playing on the right, ran very strongly before going into touch. After the line-out Sprong scored. E. E. Neser did not succeed in converting, and nothing more was scored till ends were changed.

C. L. Steyn was at his best this second half and, with him as centre, P. K. Albertijn played a perfect game. Good combination between them put Guy's in with another unconverted try. The forwards just at this point were in very good form. All did well, but no one will grudge an extra word going to L. K. Watson, or that most promising recruit, E. A. Fouraker. E. L. Sprong very cleverly changed his tactics for the next score, going left, and Hirschberg went with success for the corner. He gained his try with but a second to spare, as Morton had almost reached him at the moment of scoring. Steyn next got a try, and then came his great effort. From his own half of the field, he secured the ball and shot away like a hound from the leash. Never hesitating, he left his field behind, left Morton standing, and finished up a grand run behind the posts. Van Schalkwijk goaled and later L. K. Watson gained Guy's last try.

The team work in this match reached a very high point. From W. D. Doherty downwards all played well. The forwards with their heeling and dash in the open, the backs with their accuracy and determination, combined with unselfishness and much clever headwork gave a very polished display of the open threequarter and half back game, and last, but not least, one can commend E. J. Crisp. Though he was not overtaxed with work, one felt the Guy's line safe behind this steady and unflurried keeper.

Final score, Guy's, 2 goals 5 tries (25 points), to Nil.

Guy's Team—E. J. Crisp, A. Hirschberg, J. G. Van Schalkwijk, P. K. Albertijn, C. L. Steyn, F. Bekker, E. L. Sprong, W. D. Doherty, A. H. Shelswell, W. H. Taylor, G. Zondagh, E. E. Neser, L. K. Watson, P. G. Harvey, E. H. Fouraker.

GUY'S v. PLYMOUTH ALBION.

Guy's played Plymouth Albion at Honor Oak Park on November 19th. This is the first time a Plymouth team has visited us; it is to be hoped it will not be the last.

Plymouth sent up a very strong and very heavy team, and W. H. Doherty and his men looked, and were, men of a much smaller build, although F. J. Biddle, who has come into our pack instead of A. H. Shelswell, did his best to belie the suggestion that the Guy's pack is composed of smaller men than usual. But in the first 35 minutes Guy's forwards held their own, and got the ball much more

often than the Devon side. Some passing was indulged in, but we could not get far. Once the left wing, with Steyn on the outside, received a good pass from the scrum base, where Bekker was as sound as ever, via Sprong and Albertijn, and only a few yards were between us and a try. The Devon men rushed back, but Crisp fielded and kicked beyond half-way. Then came an infringement by a Devonian, and a punt to touch followed, but soon another penalty ensued, just within shooting range. E. E. Neser kicked a lovely goal. From the drop-out the visitors dribbled and picked up. Their halves and centres got the ball, but their passing was poor and the wings had no chances. Our own passing was safe enough, but the visitors were bottling us up with their quick following, while their tackling was very thorough. Neser made another good attempt at kicking a penalty, so near that the referee had to consult as to whether a goal had been kicked or not. The forwards then indulged in some passing, and Van Schalkwijk finished off the good work with a try that was not converted. We crossed ends leading by 6 points.

For about 15 minutes we maintained our advantage and almost increased it, as Steyn nearly scored by the corner, but after this first quarter-hour of the second half we began to weaken, the reason being solely because of the weight and fitness of the opposing pack. Weight often flags and tries during the latter portion of a match, but in this case physical fitness combined with weight told its inevitable tale, and our men of lighter build, but equal pluck, had to admit that the strenuousness of the earlier play had wearied them. Still, they stuck at their task gamely. Crisp, as cool and safe as at a pretice, kept Devon out, until fortune beat him. Several high punts had been unproductive for Plymouth, and two drops at goal missed. Butcher failed to goal a penalty against us. Then a high punt was fielded by Lee, who scored close in, but no conversion followed. Hence Guy's won a very hard game by 1 penalty goal 1 try (6 points) to 1 try. Guy's have a wonderful record to date, and especially so, if the calibre of the opposing teams be well considered. Our only defeat was at the hands of Gloucester, and we have beaten Catford, Coventry (twice), Harlequins, Bristol, Old Blues, Cambridge University and Plymouth Albion.

Guy's Team.—E. J. Crisp, A. Hirschberg, J. G. Van Schalkwijk, P. K. Albertijn, C. L. Steyn, F. Bekker, E. L. Sprong, W. D. Doherty, E. E. Neser, W. H. Taylor, E. H. Fouraker, G. Zondagh, F. J. Biddle, L. K. Watson, P. G. Harvey.

GUY'S "B" v. ROYAL VETERINARY COLLEGE.

On Wednesday, October 26th, the "B" fifteen travelled down to Surbiton and met keen opposition at the hands of the students of the Royal Veterinary College.

Being but the second match of the season, one could not be disappointed at the form shown. The forwards worked well, and, particularly in the first half, the ball came out smartly from the scrum. The backs were not exactly up to form, and the handling was not too good.

At Centre Berry worked hard and kicked well, and was successful in scoring a try in the first half. This was not converted.

In the second half Finnimore was successful in crossing the opponent's line for an unconverted try.

Our opponents were unfortunate in not scoring. Twice the forwards looked dangerous, and once, a good threequarter movement would have ended in a certain try, when, as a result of a tackle from behind by E. Orsmond, the corner flag was knocked down.

A good, hard game ended in the favour of Guy's by six points to nil.

Guy's "B" Team—Huskisson, Young, Berry, Henderson, Aung, Finnimore, Morrison, Jacobson, Ive, E. Orsmond, Holloway, Estment, Eckhoff, Brayfield.

Hockey.

GUY'S v. R.E.'s (Chatham).

Played at Chatham on November 12th, Guy's did very well in winning by 3 goals to 1, in spite of the fact that the Sappers were not up to full strength. The first goal came from Schollum, a few minutes from the start, after a good piece of combination in which most of the forwards shared. The Sappers soon equalised, and would have scored several more goals had it not been for the excellent exhibition of goalkeeping by Baugh. The second goal was also scored by Schollum after about twenty minutes' play; the final goal being scored late in the second half by Owen, after a scramble in goal. In this match Guy's probably played the best hockey that they have played for some considerable time, every man pulled his weight. Particularly noticeable were Slater, who throughout the first half was easily the best half on the field; Bowen who very safe at back, and as mentioned above Baugh in goal.

Guy's Team—Baugh, Bowen, Eglington, Spurrell, Sleater, Gathergood, Owen, Duckworth, Schollum, Kingsbury, Hunt.

GUY'S v. RICHMOND A.

This match, played on Saturday, November 19th, at Forest Hill, resulted in a win for the Hospital, by 11 goals to 2, the visitors playing one short throughout. The game was too one-sided to prove interesting. Scorers for the Hospital were—Schollum 3, Osborne 3, Owen 3, Hunt and Slater.

The Hospital 1st have lost only one match this season; the combination of the forwards is improving, but is far below required standard. One sees patches of combined play, followed by individual and ragged efforts. Until our inside forwards learn to keep that ball swinging in and out by drawing defence and judicious short passing, our attack will certainly fail against a first-class defence. The majority of the passes are much too hard, while one frequently sees forwards out of their positions. The forward line is fast and shooting, except from corners, good. Half-back play is better than last year, especially in attack. Back play may also be said to have improved; one does not notice the foot so much in evidence. Goal-keeping—the Hospital is well served here, having one or two good men to draw from.

Boxing.

OXFORD v. GUY'S HOSPITAL.

In spite of the many attractions of the evening of the 5th November, there was a full house at the Gymnasium last Saturday for the above meeting. Spectators were rewarded by having as fine an evening's sport as could be wished for, each bout being full of thrills and interest. The Varsity won by five events to two, but only one of their victories was a runaway affair, this being in the first of the Middle Weights, when C. S. Elton (New College) set about H. Richards (Guy's) with such effect that the bout was stopped in the first round. Elton has a damaging punch, in which is combined speed and initiative, and should go far with more experience.

S. P. Meacock (Guy's) had little difficulty in disposing of W. H. Collander-Brown (St. John's) in the first round of the Bantams. The loser was, as always, full of pluck, but was up against a very determined opponent, who lost no chance of taking advantage of Collander-Brown's fixed resolve to stop every flush hit with his face. This way spells inevitable defeat.

J. G. S. Thomas, the Oxford Captain, outboxed F. G. Mayne (Guy's) in the Lights. I have seen Thomas box better, and he was not absolutely at the top of his form. But his display was of the usual finished kind which it is a treat to watch, and it will be an unfortunate day for Oxford when he goes down.

P. G. Bell (Queen's) also went the full distance with G. V. Lloyd-Williams, of Guy's, in the Welters. He had against him an opponent who boxed in the most sporting and cheery fashion, generally "taking it" all the time and coming back for more. The Guy's man is a real glutton for a scrap, and it is greatly to his credit that he went the three rounds with such a craftsman as Bell. At one time it seemed (in the last round) that he had got Bell a bit dazed. It was a topping contest.

H. Trafford (Guy's) lost to C. P. Blacker(Balliol) in the Middles after three extraordinarily good rounds. There was little to choose between them at the finish, but the judges' verdict was coincident, and so Oxford gained another point.

In the Light Heavies an extra round was ordered between N. W. Holloway (Guy's) and the Hon. I. Grenfell (Christ Church). The general opinion was that this was unnecessary. Grenfell showed very greatly improved form on his previous performances, and has come on at least fifty per cent. He has learned at last the value of a straight left, and that elbows close to the side form an efficient guard against right and left body blows. His opponent, Holloway, lost by disregarding these salient facts after a very sporting encounter. It is stated that Grenfell will not be in residence after this Term. This will be a very great pity, if true. For the sake of Oxford boxing I hope this may not be so. He could be one of the best boxers Oxford has turned out for a long time at his present rate of improvement.

In the Heavies W. H. Summerskill (Guy's) gained the verdict over D. C. P. Phelips (New College) after an extra round. Phelips, who was giving away weight and had boxed at short notice, put up a fine show. Many thought he had won with a margin at the end of the third round, but the deciding verdict went against him. I do not think either contestant would cavil at the decision, and that means a lot after such a well-fought bout. Summerskill had the style, Phelips had the punch. When he blends the one with the other he will be a very dangerous customer.

The Three Rounds Exhibition between F. L. Godfrey (Merton) and Jack Morley (Instructor) was full of information and a welcome addition to the programme. Godfrey should be marked down for future notice, and Jack Morley was, well, just Jack Morley! and that means that he showed all the experience gained from a worthy progenitor's careful training. Alf Hewitt is the Guy's instructor, and gave us a very pleasing three rounds with S. P. Meacock. The old-time warrior was in huge form, and delighted us immensely. There hasn't been such a good show for many a long day in the Gym., and one hopes to see many more such. Colonel Morgan was referee, and Lieut. W. Hammond the genial and expansive M.C. The time was kept by the Senior Secretary, C. B. Gull, M.A. The Chief Constable of the City was present, and made a very appropriate speech at the subsequent supper. Amongst the visitors was Major E. S. M. Poyntz, formely Captain of the Somersetshire Cricket Team. Altogether a very sporting show.—From "The Isis."

Specialities.

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London Office:—Brighton Chambers, Denman Street, S.E. 1.

Ambrosia is the name given to a dry milk powder prepared by the Company at Lifton, in Devonshire, from the richest milk in the district.

It is made under the most hygienic conditions, and is more especially intended as a Milk Food for Infants, Nursing Mothers, and Invalids.

The analysis given shows that the full nutritive value of the cow's milk is maintained, and this Preparation should, therefore, serve its purpose.

Moisture	1.60	per cent.
Proteins	28.71	,,
Fat	29.29	,,
Milk Sugar	35.20	,,
Mineral Matter	5.20	,,

It is sold in ½lb., 1lb. and 2lb. tins at a moderate price.

The Company will be pleased to forward samples to Medical Men on application.

Marriages.

MAHON—EMMETT-ADAMS—On October 15th, 1921, at St. George's, Hanover Square, Edward M. Mahon, of 52, Upper Brook Street, to Bertha Emmett-Adams, of Sydney, Australia.

JOYNT—MYRON.—On October 5th, 1921, at Wolvehoek, Orange Free State, Malcolm Cyril Joynt, of Ngamakwe, Transkei, Cape Province, to Alexa Isabel Myron, of Wolvehoek.

TILBURY—RUDDERFORTH. — On November 9th, at the Savoy Chapel, Robert Tilbury, M.R.C.S., L.R.C.P., of 235, Queen's Road, S.E., to Kathleen Irene Rudderforth, of Blackheath.

ED.—A. T. R.

GUY'S HOSPITAL GAZETTE.

VOL. XXXV., No. 872.] DECEMBER 10, 1921. [NINEPENCE.

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Passim.

AT a meeting held at the Mansion House on November 28th, representatives of the several Metropolitan Hospitals discussed ways and means of raising more money towards their ever-increasing expenses. Owing to the present financial stringency and to the decrease in the purchasing power of money, all the hospitals are, without exception, unable to maintain solvency. The British public are so used to our diurnal cry for assistance, that they do not, or cannot, help to help us out of our difficulties. So much is this so, that representatives of a companion hospital have gone (unofficially we believe) to New York to try to obtain American dollars to make up for the English pounds which they cannot conjure up at home. Though we cannot but admire the irresponsible originality which hit upon this latest "stunt," we nevertheless absolutely deprecate the principle upon which it is based. Charity should begin at home and should end at home. We do not think that the hospitals here would welcome the importunities of, say, Two Terrible Toughs of Tympanoville, Tennessee, if they came over here soliciting subscriptions for their local infirmary. America has her own sick and her own hospitals to support without being asked to share the burden of ours. London may not be as rich as New York, but it is not poor enough yet to have to ask its Trans-Atlantic sister for alms.

But we digress; let us return to our meeting, and to the plans which were put forward for coaxing more money from Londoners for the support of their hospitals.

The chief decision which was come to was that hospitals should co-ordinate in their appeals and in their propaganda. It was proposed that during one week in May next year a combined effort should be made to collect throughout London for all the hospitals. Various means of eliciting alms were suggested, the chief being that of a pageant, which would parade the different districts, collecting for the common good. It was also suggested that during this week the hospitals should be opened to the inspection of the general public, so that they might be able to see for themselves the work that was being done. (Incidentally this might help to lessen the present day difficulty of obtaining a sufficient number of nursing probationers.)

It was estimated that by all the suggested means a sum of £50,000 might be raised. Though this seems at first sight to be a great

help in our present hour of trouble yet when it is divided out less than a thousand pounds will go to each hospital. So that it seems that though we must welcome this scheme and any other that will bring in the sadly needed money, we must not build our hopes too high upon it.

Meanwhile what we can do to help ourselves is to economise more and more rigidly. There are many little items which, taken alone, seem not to matter, but which all together run away with large sums of money. Every bandage that is wasted, every prescription that is given unnecessarily, means something, and by taking care of these pence we may be able to gain more pounds than we would by all the pomp and ceremony of a grand and expensive pageant.

Preparations for the usual happy Hospital Christmas are now in full swing. Everywhere one goes one catches glimpses of gaily coloured flowers, and ornate lampshades in their covert course of manufacture. Although the note of gaiety does not seem to have been lessened yet it appears that this year economy is also being studied. Last year's frames for shades have been brought out from the dim and dusty cupboards in which they have spent their summer, and are being redraped in crêpe.

Much to the joy of the other residents in the College, the Niggers have now migrated with all their full array of drums and castanets to the Physiological Theatre. Here, far from the maddened crowd, they practise in peace. From the Park their efforts sound rather grand, almost musical (which, to say the least, is unusual for the Niggers). We trust that this is not merely a case of distance lending enchantment—and that they will not belie this early promise, when they appear in the Wards at close quarters on Boxing Day.

It is rumoured that this year we shall see once again a Residents' play performed. The libretto, we hear, is already months old, and rehearsals have begun in earnest. If this tale is true, it is good news indeed. The present generation of students does not realise what it has lost in losing this yearly skit, which offers such a wonderful opportunity for topical wit. It is only when we read those books of the words, which have survived from pre-war Christmases, that we realise what masterpieces of quip and parody some of the plays were. We feel sure that the Residents of to-day having once put their hands to the plough, will not look back (save with a pleasurable sense of superiority) to the works of their predecessors.

Messrs. Ash & Co., following their usual generous Christmas custom have presented the Hospital with a number of Christmas cards which will be sold for the benefit of the Hospital funds. The cards may be seen in the Wills Library and the Matron's Office, where they are on sale. There are several different types, most of them being illustrated by different views of the Hospital. Their price varies, some are more elaborate than others, but all are inexpensive; and all receipts go, without any deduction, into the Hospital coffers. So we hope that all students (and nurses too), will take this opportunity of saving money for themselves and for the Hospital this Christmas.

On Wednesday last the Pupils' Physical Society met at St. Thomas's Hospital in conjunction with the St. Thomas's Medical and Physical Society. A very interesting and enjoyable evening was spent in the discussion of several clinical cases. As was to be expected, Guy's were outnumbered greatly by their hosts (there were at least four St.

Thomas's men to every Guy's man present). It was a pity too that so few senior men were able to be present. However, when St. Thomas's pay the return visit to Guy's we can rest assured that the ratio will be reversed and our guests will be able to see that at Guy's the Physical Society is a living and a flourishing body.

On another page will be found the acknowledgement which the Hon. Treasurer of the War Memorial Fund makes of subscriptions recently received. His list is still open, and his needs are still unsatisfied.

We are very glad to be able to record the appointment of Mr. J. C. V. Braithwaite, to be Assistant Physician to the Queen's Hospital for Children, Hackney Road. This is an unusual distinction, which Mr. Braithwaite has achieved, for he goes straight from house-officership at Guy's, to the Assistant Physicianship of another hospital.

Guy's were unluckily unable to pull off the double event at Rugby, which we looked forward to in our last "Passim," that of beating both of the Universities in one season. After having beaten Cambridge at Cambridge, we lost by a single point to Oxford at Honor Oak Park. Though we do not begrudge Oxford their narrow victory—for both of their tries came from sudden bursts of clever play, and both were converted magnificently—yet we feel sure that even the most rabid of their supporters will agree that, considering all things, their's was a lucky win. The Guy's team, however, more than compensated for this disappointment by their splendid play in their next match, when they beat Swansea, reputed to be the best team this year in Wales, by nine points to nil.

Guy's Hospital Ladies' Association.

Three Christmas Dances will be held in the Court Room, Guy's Hospital (by kind permission of the Governors). Two Cinderella Dances, on Tuesday, December 20th, 1921, from 8 to 12, and on Wednesday, December 21st, 1921, from 8 to 12. Also a Children's Dance (Fancy Dress optional), on Thursday, December 22nd, 1921, from 6 to 10 p.m.

Tickets, 7s. 6d. each, may be obtained from the Hon. Secretaries. Early application is desirable as the number of Tickets is limited. In previous years the Supper and Music for these Dances have been given by friends. The Committee do not feel justified in again asking for this, but will be grateful to any who are unable to take tickets if they can help in money or in kind towards the expenses or the Supper.

The Proceeds will be devoted to a Fund for the Endowment of a Cot in the Hospital.

Honorary Secretaries: Mrs. R. P. Rowlands, 12, Queen Anne Street, Cavendish Square, W.1., and Mrs. H. L. Eason, Superintendent's House, Guy's Hospital, S.E. 1.

Papers by Guy's Men.

F. D. Saner, F.R.C.S., Gangrenous Intussusception; Resection; Recovery, *Clinical Journ.*, November 23rd, 1921, p. 734.

J. B. Parfitt, L.R.C.P., M.R.C.S., L.D.S., R.C.S. The Treatment of Pulpless Teeth, Proc. Roy. Soc. Med., xv., 1921, Sec. of Odontology, p. 1.

W. H. Ogilvie, M.Ch., Resection of Shaft of Right Humerus for Fibrous Osteitis, *ibid.*, Sec. of Surgery, Sub-section of Orthopædics., p. 1.

A. E. Sawday, M.B., A case of strangulated Obturator Hernia, *Lancet,* December 3rd, 1921, p. 1159.

W. M. Mollison, C.B.E., M.Ch., F.R.C.S., Diagnosis of Acute Mastoiditis, *Clinical Journ.*, November 30th, 1921, p. 737.

A. H. Tubby, C.B., C.M.G., M.S., Orthopædic Surgery, *Practitioner,* cvii., 1921, p. 397.

Interesting Cases in the Wards.

Cases under Dr. Hurst, Dr. Hunt, and Dr. Symonds—

Addison	11.	Pernicious anæmia.
	14.	? Subacute combined sclerosis.
	17.	Hodgkin's disease.
Mary	35.	Disseminated sclerosis.
Stephen	38.	Tabes.

Sir Alfred Fripp's Address at the Opening Meeting of the Physical Society.

(*Concluded*).

3. Keep yourself simple and young. Keep your ideals, your faith, your romance, your pluck.

"Life is mostly froth and bubble,
Two things stand like stone;
Kindness in another's trouble,
Courage in your own."

Look upon yourself, not as 20, 30, or 40 years *old*, but as 20, 30, or 40 springs *young*. Don't let your sympathy die out, however heavily it may be taxed, nor your enthusiasm, nor your optimism. Behind the unrest and selfishness, of which the world of to-day exhibits so much, and which has such paralysing results, there lurks one of the greatest sins —the sin of despair. As the Japanese proverb says, "It's the melancholy face gets stung by the bee." Laugh and the world laughs with you—for happiness is a gregarious instinct.

Physical and mental depression constitute one of the chief barriers, not only to individual happiness and effort, but to successful social regeneration.

The number of things that appear to make people ill is exceeded by the number that claim to make them well—as Goodhart, that very human and entirely delightful old teacher of ours used to say; and no one interested in human improvement can afford to neglect any agency which has proved its claims, so let us try to cultivate some of the open mindedness for which he was famous.

4. Don't cross bridges till you come to them—remember that as the old woman said, "Of all the troubles in my life three quarters never happened."

It is almost impossible to exaggerate the unimportance of many things that happen. When real troubles come look straight into the light, and the shadows will all lie behind you.

5. Cultivate the art of suffering fools gladly and answering them according to their folly. It is extraordinary what a lot of crass ignorance there is to be found in all classes—and even among people who are awfully nice.

6. Choose your friends wisely, and then keep them. By your friends you shall be known. Life is so short. It may seem to you that time passes quickly even at your present stage. I assure you this is a mere amble compared with its pace as you get older. Almost before you can turn round you will find yourself attending Biennial Dinners, and comparing notes upon the long-ago student days, and marvelling how little or how much your present pals have changed in the years that have leapt by since last you met.

"From quiet homes and small beginning,
Out to the undiscovered ends,
There's little worth the wear of winning
Like laughter and the love of friends."

There are few things more worth keeping than these friendships of our student days. Around them cluster memories which hallow them. As you grow older it becomes less easy to make new friendships that really grip.

7. Therefore don't quarrel with people. Anger has been well called "brief madness," and jealousy is the same. It is foolish, and though common, it is a very expensive luxury. And it is harmful to yourself, for one enemy does you more harm than ten friends can repair. I remember a man saying that his quarrelsomeness cost him £5,000 a year.

Try rather to see the bone of contention from the other fellow's point of view. His information, his experience, his tastes may all be so different from yours—why, the poor fellow may even be in bad health, or have a nagging wife, or a baby who keeps him awake at night! His training and ideals may be so different from yours. And after all, said and done, his way may well be good though different from yours. We all see life from a different angle.

8. So cultivate toleration. It takes all sorts to make a world, and we can't live entirely among masterpieces. Likes and dislikes we must all have, but try to avoid making enemies. No man is wholly bad—and often to know all is to forgive all!

As Lord Chesterfield said, in those excellent letters to his son, if you want to avoid being disliked, try to avoid those things which you dislike in others.

9. Maintain your independence—as Kipling says:

"Help me to need no aid of man
That I may help such men as need."

If you go into a partnership, as is very likely, see to it that your solicitor provides beforehand an honourable way out. Another warning of "Goody's" was that it is seldom wise to put down much capital, at least until you have given the partnership a good trial. Probably the commonest regret among General Practitioners arises from precipitate and binding partnerships.

10. Also your sense of humour; there is room for it, even in our profession, and there is need for it, and it is a very great help both to happiness and success.

11. And your sense of proportion. This may perhaps require some cultivation, for the early periods of life are apt to be dominated by the considerations of the heart rather than by those of the head.

The capacity to see and to grasp your opportunities comes under this head. Opportunities come to all—don't let there be any doubt about that. Of course there is good luck and bad luck, and there always will be, just as there always will be poverty, crime and suffering, but in life's work—as in your field games—the apparent instances of easy success are due less to luck, which is the superficial observer's explanation, than to that highest art which conceals art. At Cricket runs may seem very easy to get while a big stand lasts, but the subsequent batsmen not infrequently find the bowling and fielding amazingly effective. Luck loves skill.

Some people expect to be told of their opportunities, awakened from their slumbers and pushed into action; others have a flair for spotting any opportunity and acting upon it promptly, and in proportion to its importance.

"I shall pass this way but once; if there is any good thing or kindness I can do let me do it *now*, for I shall not pass along this way again."

12. Keep money considerations in their proper place. Money is an essential consideration in the world of to-day, but it should not be erected above its proper level in the mind of a professional man. You will all make money—the more difficult thing is to avoid losing it in one of the many foolish and easy ways! Doctors, clergymen and poor widows are reckoned the easiest prey of the financial sharks. We have already seen there are some things which are above all money—health, happiness, straight-dealing, are a few; there are many more, and many quotations which recall them to one's mind, such as "Money lost, little loss; friends lost, much loss; pluck lost, all lost," or Kipling's "If"; or Shakespeare's wonderful speech which he puts into the mouth of Polonius.

13. And if you have cultivated a sense of proportion you will be temperate in thought and word as well as in deed; you will be moderate and tolerant of others who think differently; you will not be averse from the use of the good things put into this life, but you will recognise the essential difference between using them and ab-using them. One is thinking particularly of tobacco and alcohol and of Kipling's wonderful line "Don't drink 'cos another man's thirsty."

In politics, in religion, in love, in tastes and feelings and views what diversity! and what a good thing we don't all desire just the same objects! How fierce a contest our life would have to be—yet how dull and unvaried! How monotonous! Thank goodness, Nature abhors monotony and so it comes about that there are many quite nice fellows who hold views diametrically opposed to one's own!

14. Finally, never look back with regret. Old unhappy far off things must recur to one's mind sometimes, but don't brood over them—the habit tends to make you a back number. How break such a habit? Well, by cultivating what I call "Switch thoughts," of a happy or useful nature. Memory has been well said to consist in the art of forgetting.

By all means look back and get all the benefit you can out of any experience, and admit that you have made a wrong move and determine never to repeat that mistake, but regret is as vain as crying over spilt milk, and if indulged in encourages the adoption of that irritating attitude of mind which is for ever starting its thoughts with those two pernicious words "if only." Why call these words pernicious? Because they are so potent for harm that they should be rigidly excluded—especially from the vocabulary of our profession which has to deal with facts as we find them.

An inveterate optimist, recovering from his seventh or eighth operation for liver abscesses, once made two remarks which showed an enviable mental attitude with regard to troubles that would have weighed down most of us. If

ever a man was justified in making heavy weather he was, for, broken in purse as well as in health, by a devastating run of bad luck, he blocked the line which would have led him to the "if only" position and switched his thoughts on to such directions as these two comments on life indicate, "Everything in life has its compensations—even a liver abscess," and "There is always a good thing on its way towards you, though you may not yet perceive it."

And now I want to thank you for the kindness of your welcome and for your attention.

Several of the points I have stressed may seem to some of you extraordinarily small; my belief is that it is these little things that count most, just as the poet spoke of "the hundred nameless little acts of love" which are so apt to get dropped out of our daily life as though there was no continued need for them. Little things are often said to please little minds—yes, but watch and you will see that one of the characteristics of true greatness is the ability still to be pleased with little things—I say true greatness, because recent colossal world-happenings have rather tended, by bringing some offices, and the men holding them, into prominence, to remind us of Dryden's great line about "war like mist" making some men, "but greater seem not greater grow."

I want also to wish you a very successful Winter Session, and a very happy issue to the battle of life which each one of you has got to fight for himself, and almost entirely by himself. Fortune will favour some, with apparent unfairness to the others, but the race is not always to the swift. Come often to the meetings of this old society; it will help to equip you for that battle; it has done splendid work in the past, and its keeping is in your hands to-day.

In wishing you success in this battle I would remind you once more that, as members of a profession which is second to none in its power for good it behoves each man who would be wise to remember six things: "To whom, and of whom, he speaks, and how, and when, and why, and where." This is a very ancient quotation, but rather a good guide for us as to the advisability of keeping secret any information our patients give us about themselves. The late Sir Richard Quain had a very effective, if somewhat pompous reply ready for any inquisitive relation or friend. He used to say: "With your ready intelligence you will, I am sure, realise why I always extend to all my patients that reticence with regard to their affairs which I am sure you would wish me to observe with respect to you own."

I have kept till the very end the weightiest consideration of all—the question of your attitude towards the things beyond our power or vision.

I ventured to advise you to keep whatever faith is in you, let me venture a step further and ask you to extend to all faiths the utmost consideration and sympathy. We all agree that tastes and feelings differ, and that there is room for much diversity of opinion. For instance, which do you consider the greater—your reason, or your will, or your imagination? Well, your answer will depend partly upon your personal feelings. Which would you rather have created—a great poem or a great opera; a great cathedral or a great step in science? Again, it all depends. There is room in this world for people who hold very different views upon the things that really matter, and there is room for all the different schools to be both successful and happy, but I don't think you will find many really happy ones among those who have not been gifted with the power of believing a little further than they can prove.

Surely the advances in Science during the past quarter of a century provide many instances of the limitation of human vision, of human conception. What, for instance, did we know of X-rays, of radium, of flying or of wireless telegraphy when we, who are now seniors, were sitting in the places you occupy to-night? All these things were beyond human conception such a short time ago, but they were not beyond human hope and faith. And so I suggest to you that faith and hope are indispensable qualities for those who would be happy and who would help others to be happy in this world.

Religion is a matter too private for such a gathering and such an occasion as this. I always admire the way Disraeli kept his secrecy on that great topic. The reply he gave, when one of the ladies who exercised great in-

fluence over him, thinking that she had a good opportunity of extracting a declaration upon the vexed question as to which religion he really subscribed to, dared to say, "Now do tell me—what *is* your religion?" was, "Ah! certainly I will! it is the greatest of all religions."

Yet I would like to venture one step further still and suggest to you that from whatever view point we regard creation—whether of directly divine origin, or indirectly divine through natural processes—it is impossible to conceive the evolution of the world as a matter of pure accident, it must then be a matter of design.

As Troward puts it:—

"The physical history of our planet shows us first an incandescent nebula dispersed over vast infinitudes of space; later this condenses into a central sun surrounded by a family of glowing planets hardly yet consolidated from the plastic primordial matter; then succeed untold milleniums of slow geological formation; an earth peopled by the lowest forms of life, whether vegetable or mineral; from which crude beginnings a majestic, unceasing, unhurried, forward movement brings things stage by stage to the condition in which we know them now. Looking at this steady progression it is clear that, however we may conceive the nature of the evolutionary principle, it unerringly provides for the continual advance of the race."

Which reminds us of a stanza from an individual who must have been considering the universe from an almost identical angle. It seems to me to help us as members of a scientific profession (who come across, in our daily work, many experiences which appear at first sight to conflict with orthodox theology) to feel in unison with others who may happen to contemplate the same things from a totally different angle.

"A fire mist and a planet,
A crystal and a cell,
A jelly fish and a saurian,
And caves where cave-men dwell;
Then a sense of law and beauty,
A face turned from the clod,
Some call it evolution,
And others call it God."

Presidential Address delivered by Mr. Pearce, at the Meeting of the Dental Society, on Oct. 20th, 1921.

GENTLEMEN,—I thank you for the honour you have done me in again electing me President of this Society.

This Society was founded in 1894 and although I cannot lay claim to being an original member, I have been a member for twenty-four out of the twenty-seven years of its existence. I am afraid that latterly I have not been able to attend its meetings as often as I should have liked, but I have always been keenly interested in the accounts of its proceedings.

The Society was founded for "the consideration of matters generally or specially appertaining to Dental Science." But even before the foundation of this Society, matters relating to dentistry were discussed at Guy's, and if you will look up some of the Transactions of the Physical Society, which you will find in the Library, you will discover many papers by former Dental Surgeons to Guy's, papers which will well repay you for reading even at the present day. When the Dental School was instituted, it was not long before the want of such a society as this was felt, and this Society was founded and has, I think, amply fulfilled the objects for which it was instituted. The wording of Rule Two, which I have just quoted, as the object of the Society does not preclude the reading of papers or discussions on subjects other than dentistry. It very wisely merely states that the subjects must "generally or specially appertain to dental science." This leads me to a point which I wish to emphasise and that is, that we who are occupied, most of our time, in a highly specialised field of work, may tend to become narrow in our outlook unless we endeavour to keep abreast of the times in subjects allied to dentistry.

The sciences which are allied to, or have a bearing on dentistry, are so very numerous that we ought to have no cause to become narrow. There are of course all the various branches of Medicine and Surgery, some of which touch our own specialty very closely; then again there are chemistry, metallurgy and physics, all of which are advancing in knowledge, and this

new knowledge, may tend to elucidate some of the problems which beset us in our work. Whilst I think we should endeavour to keep informed on the advances in these allied sciences, please do not think that I decry the study of purely dental matters, I am taking it for granted that a keen man will keep abreast of the advances in our own specialty, but I feel that even these special subjects will be advanced still further by the study of allied subjects with which they are frequently intimately bound up. Dentistry is badly in need of research workers, there are so many problems connected with our every-day work which need elucidating.

The other great object which this Society fulfils is to teach you to take your place later on in the larger professional societies; by attending the meetings of this Society, by reading papers or presenting casual communications, and by discussing them among yourselves, you are fitting yourselves to take an active part in the discussion of matters relating to our profession. Indeed, I think that this is perhaps the greatest of the advantages of a society of this kind; just as the Dental School is the place where you learn to undertake the work on which you are to be engaged throughout your life, so this Society is your *training ground in public speaking and in* instilling into you the true professional spirit, and enabling you to take your part in moulding and improving the profession as a whole. I have not a very high opinion of the man who refuses to join any of the professional societies, and who holds himself aloof from his fellows, but I think he also deserves pity, as he never attains the fullest value from his life. The very essence of professional life is, I think, gained by association with your fellow workers, learning from them, and it may be, assisting them by some knowledge which you yourself may be able to impart. This Association is good, not only for the individual, but for the profession as a whole, and tends to do away with those petty jealousies which were formerly so prevalent among men engaged on the same work. I would go even further than this and say that the knowledge given and gained in these associations of our fellow workers is bound to lead to the good of the community as a whole.

Gentlemen, the year 1921 will, I feel confident, prove a great landmark in the history of our profession. You probably know that as a result of the findings of the Departmental Committee, which was appointed to enquire into the evils arising from the practice of dentistry by unregistered persons, an Act has been passed by Parliament which will in future absolutely prohibit such practices. It further provides that for the future everyone who practises dentistry will be subject to the control of a Board acting under the aegis of the General Medical Council, which should be instrumental in doing away with the gross evils which have been associated with the practice of dentistry by unregistered persons for so long. The Dental Profession have been called upon to make a great sacrifice in order to get this Act passed, by having their Register opened to men who have not qualified by examination, for entry into the profession. But even though this may mean that it will be at least a generation before the Register is entirely composed of the names of men who have qualified by examination after a course of study and practice at a dental school, yet I feel sure that this sacrifice will not be in vain and will eventually prove of the greatest benefit to the profession. But not only will the profession gain, but what is more important still, the community as a whole will be benefited by being assured of skilled work by men trained at a dental hospital and only registered after passing an examination on their fitness to practice.

I can look back on over twenty-five years connection with the profession you are entering, and even the great disabilities under which it has laboured, owing to the failure of the Act of 1878, have not prevented it from advancing rapidly, not only in regard to its science and practice, but also in the estimation in which it is held by the public. I feel confident that the next twenty-five years will see far greater progress and it is for you, who are entering it, to see how far this progress can go.

Gentlemen, I desire to welcome the new members to this Society, I have no doubt they have all read the very admirable advice given them by Mr. Hopson in the GAZETTE; I need not therefore add to that, indeed I could not do so if I wished to. I do, however, congratulate you on becoming Guy's men, I feel sure that you will never regret your choice of school, but rather will be able, in years to

come, to look back as I can and feel that it was the most fortunate and best decision you ever made.

But whilst congratulating you, I would also impress on you that Guy's has a great dental past; Guy's was the first hospital in Great Britain to institute lectures on Dentistry, as far ago as 1799. Many famous Dental Surgeons have been connected with Guy's and they have given us a great reputation and have set us a very high standard which it behoves us all not to sully, nay, more, it behoves us to maintain, and if possible enhance this reputation. To those of you who come to us from abroad, may you learn at Guy's and in this Society something which you will take back to your own country and which will stimulate you to improve and strengthen the existing dental societies, and it may be that some of you may be instrumental in forming new societies and even in founding new dental schools. At any rate you may always rely on those of us who remain at Guy's being interested in your careers.

Gentlemen, I hope that during the coming year we shall have papers read before us which will prove both interesting and instructive, and that they will promote a healthy discussion, without which no subject is fully investigated.

Guy's Hospital War Memorial.

Subscriptions received from Dec. 18th. 1919, to Nov. 30th, 1921.

Amount already acknowledged	5,077	7	10
Pearson, Maurice	5	0	0
Bulleid, W. A. (2nd instalment)... ...	5	5	0
Viljoen, W. J. Rousseau	5	5	0
Hawkins, C. F. (2nd instalment)... ...	1	1	0
Thorne, J. M.	5	5	0
Mollison, W. M. (final instalment) ...	40	0	0
Rogers, W. G.	5	0	0
Johnston, T. B.	5	5	0
Attwater, G. L.	1	1	0
Kent, H. B. (further instalment) ...	10	10	0
Edridge, R.	0	10	6
Bedford, H. (2nd instalment)	5	0	0
Hawkins, C. F. (3rd instalment) ...	1	1	0
Spon, H. J. (2nd instalment)	10	10	0
"From a Sorrowing Mother and Sister"	10	0	0
Pye-Smith, C. D. (final instalment) ...	12	12	0
Owen, L. E.	1	1	0
Hirsch, V. R.	2	2	0
Atkinson, C. H.	0	10	0
Currie, J. A.	1	1	0
Osman, A.	1	1	0
Passey, R. D.	1	1	0
Ive, C.	0	10	0
Targett, W. K.	0	10	0
Alexander, J. N.	1	0	0
King, W.	2	2	0
Northfield, D. W. C.	0	5	0
Canning, H. G. R.	0	10	0
Koerner, E. H.	0	10	0
Weinbren, M.	1	1	0
Marsh, F.	0	10	0
Eason, H. L.	10	10	0
Rogers, A. T.	1	0	0
Weller, E. M.	1	1	0
Dix, A.	5	0	0
Baxter, C. W. W....	2	2	0
Campion, O. St. L....	1	1	0
Green, E. S.	2	2	0
Maizels, M.	1	1	0
Saw, S.	5	5	0
Saw, Mrs.	2	2	0
Walford, W. J.	5	5	0
Meacock, S. P.	0	5	0
Card, Mrs. J. B. C.	1	0	0
Robinson, J. F. (final instalment) ...	1	1	0
Bulleid, W. A. (3rd instalment)... ...	5	5	0
Milton, W. T. (final instalment)... ...	4	4	0
Ogilvie, W. H. (final instalment) ...	10	0	0
Hawkins, C. F. (final instalment) ...	2	2	0
Bedford, G. H. (3rd instalment)... ...	5	0	0
Fry, L. S. (final instalment)	14	15	0
Howell, J. (final instalment)	4	4	0
Wood, T. Nevill (final instalment) ...	5	0	0
George, W. S. (final instalment) ...	4	4	0
Zorab, A. (2nd instalment)	5	0	0
Harris, Rev. C. F....	0	5	0
Watkins, J. P. (balance of instalments)	4	4	0
Tyson, Wilson (final instalment)... ...	3	3	0
Knowles, C. Heygate	2	2	0
Goldie, E. G.	2	2	0
Gibson, C. G.	1	0	0
"M."	10	0	0
Craig, Sir Maurice (further donation) ...	5	5	0
Venning, Miss W. M.	1	1	0
Samways, D. W.	2	2	0
Total to November 30th, 1921 ...	£5,341	0	4

Appointments.

H. V. Croucher, L.D.S., R.C.S.Eng., Dental Surgeon to the Penge Education Committee.

Intimations of Mortality.

BY A THIRTY-SECOND YEAR MAN.

Most people consider themselves to be on a slightly higher plane than the rest of humanity. A man will make his will and insure his life, but these precautions, nevertheless, seem to him to be rather unnecessary, as his death, except as the result of an accident, appears only the vaguest of possibilities. The best way of putting it is that every man believes that God took rather more trouble over making him than in making anybody else. At Egyptian banquets, it may be remembered, a corpse was exhibited to correct this belief, while Asiatic princes employed a man constantly to remind them of their mortality.

Nowadays there are several methods of impressing upon a man his own insignificance. One is to induce him to cross King William Street on a busy morning; another is to inveigle him into the boxing ring; but far and away the best one is a prolonged course of dental treatment. He first sits down as bold as brass, firm in his conviction that what hurts other people would be quite insignificant to him, but the second and third times find him more and more reluctant to undergo the ordeal. "G-r-r," says the burr, "I'll teach you to over-estimate yourself. G-r-r. G-r-r. Just wait till the Inverted Cone comes along. G-r-r. G-r-r. Take that. Grind. Splinter. G-r-r. G-r-r. G-r-r." And the grinning manipulator continues the lesson, while the infuriated victim, reduced by the gag to a dammed incoherency, longs for just one minute's free speech in which to tell him that he dislikes puns, hates dental men in general, and loathes and detests this one in particular, and that when this business is over he will break his neck for him.

But it is the extractions which rub the lesson in. Our victim generally manages to convince both himself and his friends that nitrous oxide doesn't upset him in the least (although his desire to vomit whenever he smells rubber makes him just a *little* bit anxious on this point), but he cannot disguise from himself that the reason why he hates the man in the local room, who said, "Of course, I can't promise you *complete* anæsthesia," is that it was through him that he was convinced of his mortality.

THE EDITOR will, at all times, be glad to consider articles or sketches, provided that they are accompanied by the writer's name and address, not necessarily for publication. The payment that the GAZETTE *can offer is merely nominal. Authors who desire reprints of their papers should make their own arrangements with the printers when they return their proofs. All contributions to be addressed to the Editor, "Guy's Hospital Gazette," Guy's Hospital, London, S.E.*

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

SIR,—The enclosed note from a paper read by me some years ago before the Brighton and Sussex Medico-Chirurgical Society may be of interest in connection with your short article in the last number of the GAZETTE on the first operation for relapsing appendicitis by my old friend and teacher Sir Charters Symonds.

Below is the extract from my paper:—

"In an edition of Druitt's 'Surgeon's Vade Mecum,' published in 1877 there is a small paragraph as follows:—Recurrent typhlitis. In a case in which a man was frequently incapacitated from active work, by attacks of acute typhlitis, Charters Symonds, at the instigation of the late Dr. Mahomed, cut down upon the appendix and found it to contain a fæcal calculus which he removed, with the result that the man was completely relieved.—This is the only reference to typhlitis in the book, and the word appendicitis is not mentioned, showing how little of the subject was known at the time.

The account of the operation is recorded in the Transactions of the Clinical Society for 1885, and the following words are extracted from the remarks of Mr. Charters Symonds on the case: The difficulty very often in diagnosing the cause of sudden abdominal pain and the number of cases of typhlitis that recover, will, I imagine, long deter us from opening the abdomen and removing the appendix, and yet post-mortem examination shows that if such a procedure could have been undertaken, recovery might have been possible in some otherwise hopeless cases."

—Yours, etc.,

5, The Drive, Hove, L. A. PARRY.
17th November, 1921.

Change of Address.

Frederick Beard, *Pensions Appeal Tribunal, Court* 22, 86, Strand, W.C.

C. T. Helsham, The Walk, Beccles.

Dr. Uhthoff, 7, *Branksome Wood Road, Bournemouth.*

Cricket Club.

At a General Meeting of the Cricket Club held on October 27th, 1921, the following Officers were elected for 1922:—

President: Prof. T. B. Johnston.
Hon. Sec. and Treas.: A. G. Ensor.

Reviews.

Developmental Pathology, a Study in Degenerative Evolution. By Eugene S. Talbot, M.S., D.D.S., M.D., LL.D.Edin. (Messrs. E. & S. Livingstone.) 1921. Price 25s.

The thesis of the book is expressed in the words of the author: "Heredity is not a fixed inevitable destiny of what must be, but a map of possibilities of what may occur." He adopts the sound view that individual development is extensively influenced by environment. If this be unfavourable, it reveals its action in the form of degeneracies or arrests of development, the most important of which is an instability of the central nervous system.

To support this thesis the author brings forward much time-honoured evidence, based on morphology, embryology and anomalies and pathological states of the organs of the body. He discusses the face, and especially the teeth, at length. He shows clearly that he is no biologist, embryologist, or pathologist. His information on these subjects is evidently second-hand, with many indications that it is but half digested. Although he appears to be alive to the fact that ontogeny can only be a very shadowy recapitulation of generalised types, in so far as it is a repetition of the pedigree of the species, he fails to grasp its importance, since concrete illustrations of the phrase "arrests in phylogenetic development resemble fish, reptile, bird and mammal" recur time after time, in season and out of season. He distinguishes between arrests of phylogenetic and of ontogenetic development. But it is not at all clear why club and flat foot, or increase in size of the jaws, or failure of the teeth to erupt are arrests in phylogeny, whereas mal-development of the intestines, smallness of the jaws, and the suppression of the root or crown of a tooth are arrests in ontogeny.

There are many mistakes in the book, some of them unpardonable. No book that bears the title of "Developmental Pathology" can afford to make a statement like this: "In cyclopia the pineal body becomes an actual eye, as in certain lizards, while the paired embryonic eyes disappear." Nor can we pass over the entire lack of appreciation of the rudimentary facts of embryology displayed in the statement that every organ of the body is developed from a single cell. Funnily enough the teeth, of whose development the author appears to have some personal knowledge, are said to form an exception to this rule. We cannot agree that diminution in size is a degeneration, and fail to understand passages like this: "As the ovaries of neurasthenic women generally exhibit prominently the effects of the nervous exhaustion, the disappearance of the centrosome is not properly affected and sufficient stimulus by the spermatozoon is not secured and the offspring of these do not gain vigor to pass through the normal process of development."

Blemishes such as these, and the crudities of style and of treatment that pervade the book throughout, induce a heart-felt longing in us that authors, instead of indulging in pseudo-scientific platitudes, would limit their writings to subjects of which they themselves possess some knowledge. Advice on the safest way by which to enter the maxillary antrum is, however, out of place in a work on developmental pathology, even when it is the result of the author's own experience. There is little that is new in the book, and less still that is likely to widen the mental horizon of the reader.

The Hunterian Oration, 1921.

We were very pleased to receive a copy of Sir Charters Symonds' scholarly and instructive oration. Sir Charters took Astley Cooper as his text, and medical education as his subject. Having given a biographical sketch of Guy's great surgeon and teacher of a century ago, he proceeded to adapt Cooper's principles of teaching and to show how they might well be made use of at the present day. Sir Charters urges that less importance shall be paid to the study of minute detail in anatomy and in physiology, and that these subjects shall be taught more from the point of view of the students' future clinical studies. There should be professors of applied, rather than of pure, anatomy in all the schools. The student should also, from his earliest days, have an opportunity of coming into contact with patients, and of learning the use of the anatomical facts and physiological principles which he was being taught.

Technique of the Teat and Capillary Glass Tube. By Sir Almroth E. Wright, M.D., F.R.S., with the Collaboration of Leonard Colebrook, M.B., B.S.Lond. (Messrs. Constable & Co., London, 1921.)

In 1912 Sir Almroth E. Wright was responsible for a volume entitled "A Handbook of the Technique of the Teat and Capillary Glass Tube and its Applications in Medicine and Bacteriology," in which he described many ingenious pieces of apparatus, each fashioned from the common objects of the worker's bench, and numerous brilliantly simple methods for the evaluation—to use one of his favourite terms—of tissue response to infective virus. In so doing Wright placed laboratory workers in the domain of clinical pathology under a deep obligation, for there must be very few of the present generation who have

not been consciously or unconsciously influenced by the theories and assisted by the utensils that have emerged from the Paddington school.

Now in the present year of grace appears a second edition under the modified title of "Technique of the Teat and Capillary Glass Tube, being a Handbook for the Medical Research Laboratory and Research Ward," in the preparation of which Sir Almroth has associated himself with Leonard Colebrook, who, if our memory serves us aright, was responsible in similar association for some of the research work in South Africa on the prophylactic inoculation against Pneumonia. In its new shape the eleven chapters of the former edition have grown to fourteen, and the actual number of pages has been almost doubled.

But this expansion must be accounted a virtuous action, for the logical sequence of thought that marks all Sir Almroth Wright's writings is conspicuously present, whilst the lucid and scholarly language, if at times somewhat stilted, exercises a profound fascination over the reader and leaves even the most obtuse of students no loophole for mistaking the author's meaning.

The general arrangement of the matter remains the same; the first three chapters are devoted to detailed descriptions of the methods of working glass tubing and the manufacture of pipettes of various kinds employed in carrying out the manipulations elaborated in the following chapters. The directions are so clear and the woodcuts so helpful that very little practice is needed before any ordinarily "handy" individual can turn these indispensable tools both satisfactorily and rapidly. Then come the methods of collecting and handling blood, and the measurement of agglutinating, bactericidal, bacteriolytic, and opsonic properties. Chapters 10 to 12, dealing with the experimental methods devised by Wright and his assistants for the study of wound infections during the Great War (some of which, by the way, are described in an earlier chapter—8—and all have appeared from time to time during the past seven years either as special lectures before the Royal Society of Medicine or in the weekly Medical Journals) are as fascinating as any in the volume, for—teacher as well as researcher—Wright has always been impressed by the importance of devising experiments to demonstrate, in the most striking and unequivocal manner, his conception of the phenomena occurring in infected tissue.

The book, as to its older portions, bears ample evidence of careful revision; for eaxmple, the theoretical considerations underlying the method of estimating the alkalinity of the blood is now discussed in terms of hydrogen ions, although the method itself has undergone merely verbal alteration. Figures to the number of 151 add to the clarity of the descriptions, but, probably from notions of economy, some of the originally coloured plates now appear in black and white.

Finally we would commend to the serious perusal of every research worker the "Preface to the Second Edition" and the Appendix to Chapter 9, each in its way a gem of the first water and worthy of the widest publicity.

Pass List.

Royal College of Surgeons of England.

DIPLOMA OF FELLOW.

First Professional Examination, November, 1921.

Currie, John Alexander.
Fouché, François Petrus.
Mill, William Allin.
Parsons, Kenneth Owen.

Notices.

In connection with the Dentists Act which received the Royal assent on July 28th last, it is to be noted that the Dental Board authorised by that Act has now been appointed. Its personnel is as follows:—Mr. F .D .Acland, M.P. (Chairman), Mr. Laurence George Brock, Mr. Fred Butterfield, Sir Arthur Gerald Chance, F.R.C.S.Ireland, Mr. Dugald McCoig Cowan, M.P., Mr. William Henry Dolamore, M.R.C.S., L.R.C.P., L.D.S., Professor William Henry Gilmour, M.D.S., L.D.S., Mr. William Guy, F.R.C.S. Edin., Mr. Horace Archibald Robertshaw, Mr. Edward Loo Sheridan, F.R.C.S.Ireland, L.R.C.P.Ireland, L.D.S., Mr. John Sinclair, Mr. Holburt Jacob Waring, F.R.C.S., and Mr. Norman C. King (Registrar). The offices of the Dental Board will be at 44, Hallam Street, Portland Place, London, W. 1. All communications should be sent to the Registrar at that address.

It is interesting to observe that Mr. H. A. Robertshaw, the President of the National Dental Association, of London, has secured nomination to one of the two seats available for the unregistered on this Board. Mr. Robertshaw had a distinguished career at Owens College, Manchester, and his successful nomination is to a great extent due to the efforts put forward by Mr. F. Dyke Acland, P.C., M.P., and Mr. J. A. Seddons, C.H., M.P.

Guy's Hospital Medical School.

GULL STUDENTSHIP.

Applications are invited for the Gull Studentship in Pathology and Allied Subjects, which is now vacant.

The Studentship is open to Candidates under 30 years of age who have studied in the Medical School of Guy's Hospital, is of the annual value of £250, and is tenable for three years.

Candidates must state the scope of the investigations which they propose to undertake.

Further particulars may be obtained from the Dean, to whom applications must be addressed at the Medical School Office, not later than Tuesday, December 20th, 1921.

December 6th, 1921.

Of the many amalgamations of important Commercial undertakings which have lately been published in the Press, one at least deserves the attention of our readers, as it directly concerns the Medical, Surgical, Dental and Nursing Professions.

We refer to the announcement that Messrs. John Bell & Croyden, Ltd., the well-known Chemists and Specialists in Sterilized Surgical Dressings, of 50, Wigmore Street, London, W., have incorporated the old-established House of Arnold & Sons, Surgical Instrument Makers, of 6, Giltspur Street, E.C.

Under one control, and with new and experienced management, both sides of the business will be reorganised and considerably extended, with the result that from now onward the House of John Bell & Croyden, Ltd. will constitute a source of supply of everything pertaining to Medicine and Surgery, in addition to rendering to the Professions generally a service of unprecedented efficiency. As an instance of the latter, it should not be overlooked that from their Wigmore Street Establishment they maintain an all day and night service, whilst at Giltspur Street the repair and dispatch of Surgical Instruments will be carried out with the utmost expedition.

Many other arrangements, innovations and improvements are in hand, the result of which cannot fail to make this Firm still more widely known and favoured by those concerned.

Dental Society.

The Committee wish to bring to your notice that the Annual Dinner will be held on Saturday, February 18th, 1922, at the Connaught Rooms. The price of the tickets is 12s. 6d. (exclusive of wine).

The President, Mr. F. J. Pearce, will be in the Chair.

L. B. HELDER,
Hon. Sec.

Rugby Football Club.

At a General Meeting held in the Physiological Theatre on Monday, November 29th, at 4 p.m., the following were elected :—

"A" XV.—Captain, A. K. Van Niekerk; Vice-Captain, H. G. Close.

"B" XV.—Captain, S. H. Daneel.

"Nomads."—Captain, S. V. Strong.

Dr. John Fawcett presided; only 30 members were present.

Guy's Hospital Reports.

The New Series of "Guy's Hospital Reports" in quarterly form can be obtained at a specially reduced rate of 30s. a year by unqualified men from Mr. Winston at the Wills Library. (The ordinary subscription rate is two guineas.)

Presentation to Mr. Lane Roberts.

During the past week a presentation has been made to Mr. C. S. Lane Roberts by past and present members of the Anatomical Department in appreciation of the value of his work in the Department. During his term of office as Senior Demonstrator he quickly gained the respect and confidence of everyone, and his departure was a matter of general regret. The presentation took the form of a Roll-Front Cabinet with an engraved plate.

Specialities.

The Treasure Cot Co., 124, Victoria Street, S.W.1.

Several excellent contrivances have been devised and patented by the Treasure Cot Co. for the safety and comfort of children.

Foremost amongst these is the "Treasure Cot," which is strongly made and durable, and is so constructed that the hammock portion of the cot can be detached for washing.

This Cot folds up into the smallest compass, and can be comfortably packed in the space contained within an ordinary golf bag.

The "Treasure Crib" is another contrivance worthy of mention, having a self-locking sliding side and bars so near together that there is no possible danger.

This Company also manufactures the "Playground," forming a complete safeguard for children either indoors or out, and yet another, the "Play Table," in which a child may be amused in safety for hours.

There are excellent show-rooms at 124, Victoria Street for those interested.

THE VARIVANE CO., 4, Old Street, E.C.

For those suffering from Varicose Veins, the Varivane Co. are supplying effective laced Supports, which are of strong cotton or silk fabric.

These Supports are not manufactured in sizes, but are in every case *made to measure*, so that the wearer is assured of ease, comfort, and fit.

The material of which they are made is absolutely unshrinkable, and can be easily washed or repaired.

Advantage is claimed for them over the elastic variety, inasmuch as adequate pressure can always be maintained by the simple process of lacing.

Further, they last longer, and can be repaired as often as required at a small cost, and thus offer to sufferers from varicose veins a most effective, comfortable and economical Support.

The Varivane Co. will be pleased to send fullest particulars on application.

Football.

ASSOCIATION.

GUY'S v. COLCHESTER TOWN.

This match was played at Colchester on November 10th and resulted in a draw of 4 goals each. Three regular members of the eleven—Painter, Van Geuns and Trott—were absent owing to exams. and injuries. It was a new experience for the team to find themselves looked upon as a football attraction.

The game was fast throughout and pretty to watch. Colchester scored within five minutes before the backs had settled down. Williams scored twice in quick succession as the result of good work by Walters on the right wing. Colchester were awarded a penalty, but their Captain, thinking the Referee's decision an error, kicked in the direction of the corner flag. This action was characteristic of the excellent spirit in which the game was played. After the Colchester centre forward had brought the score level, Couch again put Guy's ahead. Colchester equalised before the interval.

In the second half play was of the same high standard, both sets of forwards indulging in smart rounds of passing. At the end of twenty minutes the Town obtained the lead, but from then on play was for the most part in our favour. Time after time our forwards all but equalised; however, it was not until five minutes from time that Williams brought the score level with a fine shot. The game finished with Guy's attacking strongly.

Team.—E. Hardy, C. A. Wakeford, A. W. Riddolls, J. Parry, D. J. P. O'Meara, J. C. Hewetson, L. Walters, W. Nicholls, L. S. Williams D. H. Couch, and V. R. Morgan.

To effect a draw was a fine performance, and the XI. are to be congratulated. The forwards were excellent and combined well. The reserve wing halves came through a stiff game with great credit; while O'Meara was sound in the centre, his heading being a feature of the game. The backs played well, and Hardy had no chance with the shots that beat him.

GUY'S v. OLD ALDENHAMIANS.

Played at Honor Oak Park on Saturday, November 12th, and won 2—0. Scorers, Walters and Williams. Although without Riddolls and Trott, we had no difficulty in defeating the Arthur Dunn Cup finalists of last year, our superiority being much greater than the score indicated.

Team.—E. Hardy; C. A. Wakeford, D. H. Couch; O. F. Painter, D. J. P. O'Meara, J. C. Hewetson; R. Van Geuns, L. Walters, L. S. Williams, N. Cohen, and H. Wayman.

GUY'S v. ROYAL SCHOOL OF MINES.

Played at Chiswick on Wednesday, November 16th. The result was a win for the Hospital by 3 goals to 2. Scorers, Williams (2) and Walters.

Team.—T. Wooldridge, C. A. Wakeford, A. W. Riddolls, O. F. Painter, D. J. P. O'Meara, J. C. Hewetson, W. Nicholls, L. Walters, L. S. Williams, L. A. S. Trott, and H. Wayman.

Other results :—

November 19th—v. H.A.C., away, lost 2—5.

November 23rd.—v. Schoolmasters' XI., Eastbourne, won, 4—3.

GUY'S v. COX & CO.

1st Round Private Clubs' Trophy (A.F.A.).

The Soccer had their first Cup Tie of the season on November 26th, when they played Cox & Co. in the above competition. It was unfortunate that the game had to be abandoned owing to fog after 60 minutes' play, when the score was 1 all. As far as one could see the teams were evenly matched, and the replay should be a fine game to watch.

The first half there was no score; after the interval Cox & Co. scored, but Williams soon equalised.

Team.—E. Hardy, C. A. Wakeford, S. E. Sennitt, O. F. Painter, D. J. P. O'Meara, N. Cohen, R. Van Geuns, L. Walters, L. S. Williams, D. H. Couch, and V. R. Morgan.

GUY'S v. LONDON DAY TRAINING COLLEGE.

1st Round London University Football Cup.

Guy's defeated London Day Training College at Honor Oak Park on Thursday, December 1st, by 6 goals to nil, and thus qualified to meet Bart.'s in the 2nd Round of the Varsity Cup.

Team.—E. Hardy, C. A. Wakeford, S. E. Sennitt, O. F. Painter, D. J. P. O'Meara, J. C. Hewetson, R. Van Geuns, L. Walters, L. S. Williams, D. H. Couch, and V. R. Morgan.

RUGBY.

GUY'S v. LONDON SCOTTISH.

All the morning of November 26th one wondered if the fog would prevent this fixture being played at Honor Oak Park. It lifted just in time, and notwithstanding our contemporaries' talk about groping in the fog, visibility was quite good till fifteen minutes from the end, when the pall came down again, and almost blotted out the players. A. Daneel re-appeared for the Hospital in place of Hirschberg; H. Graham-Davies also returned; Albertijn was resting a damaged knee.

The Scottish were the first to score; weak tackling on our part conduced to their success. Langlands was tackled and held up, lobbing the ball to MacRoberts, who sent Williamson in. The first-named should have been downed; much of the Guy's tackling is too high. The shot at goal was not successful. The temporary reverse, as usual, seemed to buck the Hospital side up, and they settled down to some very hard scrummaging. After about five minutes Sprong threw a long pass to Van Schalkwijk who cleared the field almost at once and passed, on nearing the full back, to Graham-Davies, who ran to the post. Van Schalkwijk converted, and but a short time after scored a triumph by clearing the way magnificently for Steyn, who gathered at top speed to run in on the left. Neser missed the extra points. Daneel made a good attempt to score on the right after very clever play by Watson. Fouraker was also prominent.

After half time there was some really brilliant handling by Watson, Fouraker and Bekker, who got our third try, which Neser could not manage to convert. The Scots were by no means done with. They scrummaged well, and much of their footwork in the open was lusty, if not exactly under control. But behind their pack they were not very well served, except in the full back position. Here, G. C. Fortune, who had plenty to do, did well. Our three-quarters, well served by the prompt heeling of the forwards, had several chances, and Van Schalkwijk made the most of his opportunities. Sprong, Van Schalkwijk, and Steyn were responsible for the last try that came our way. Then, as the fog commenced to thicken, Langlands got another unconverted try for Scotland. Both sides finished strongly, if anything the visitors were the fresher. It was a bad afternoon for playing, and fog always tries a player's wind. Just before the close Doherty had a nasty ankle injury and had to be carried off. It is much to be hoped that his injury is not too severe to keep him out of the important matches now about to be played at Honor Oak Park. Guy's, 1 goal 3 tries (14 points); London Scottish, 2 tries (6 points).

Team.—E. J. Crisp, A. Daneel, H. Graham-Davies, P. K. Albertijn, C. L. Steyn, F. Bekker, E. L. Sprong, W. D. Doherty, R. F. H. Duncan, E. E. Neser, E. H. Fouraker, F. J. Biddle, P. G. Harvey, G. Zondagh, L. K. Watson.

GUY'S v. OXFORD UNIVERSITY.

It was unfortunate that the Hospital had to take ber 30th, without the captain, W. D. Doherty. His ber 30th, without the captain, W. D. Doherty, his play is so heartening and his presence so exhilarating that his absence is always felt. But even he would scarcely have turned the scale in our favour. The Hospital were beaten by 10 points to 9; 2 goals to 3 tries. One does not grumble at defeat, but at ill fortune. Oxford were lucky—they would be the first to admit it—though, for the first fifteen minutes or so, they played with great dash and got the ball more often than our men. Quite early Neser accepted a pass in front of goal and went over, but was called back. Graham-Davies also caught an awkward delivery and went away, to suffer the same fate. Forsyth, Oxford's full back, punted well, and from midfield David sent Van der Reit away to pass to Macpherson who scored. It was a good try and Lawton goaled. Going for the ball earlier in the game, from a cross kick by Steyn, Albertijn as a result appeared to have gone slightly lame. Perhaps this was the reason so little running was done by our three-quarters. Their kicking was splendid, and so was Sprong's, but it seemed a pity to see Bekker's good work in throwing the ball out comparatively wasted on a stand-still line. Albertijn, by smartly following up, scored our first try, which was the result of a crosskick by Graham-Davies.

This was all the scoring till the interval, and as the game progressed the Hospital forwards improved all the time. They were all good, but in the tight work a special word should go to Zondagh. Neser has seldom played better. *The Daily Telegraph* says he was superb, and mentions also the excellence of Taylor, Duncan and Watson. Of Bekker, *The Daily Telegraph* expert says, "He must yield pride of place to Kershaw, but it would not be difficult to defend his claims as a scrum worker against those of almost any other modern scrum half back." High praise indeed from such a writer as Colonel Phillip Trevor. The writer goes on to say that "the case for Albertijn as a centre three-quarter back could, perhaps, be put even higher than that."

The second half had not progressed far before Taylor put Guy's ahead with an unconverted try, and very shortly afterwards Albertijn put into action his own particular method of selling the dummy, opening up an opportunity for Van Shalkwijk to gain a try. This also failed to have the extra points added. Our forwards continued to play well, and it seemed as as though we had the game well in hand. Oxford were not often in our territory, and when opportunity occurred Daneel punted well for touch. His fielding was also good. The play was nearing the end when from a short line out Pitman, unmarked, got clean away and passed Daneel to score a try, which Lawton goaled in good style. One almost thought Steyn should have stopped Pitman, but the light was failing, and this happened on the far side from the stand. Still, Guy's went all out to win. A great shout went up as Albertijn crossed the line, and great was the disappointment when no try was allowed. The three-quarters played well, but no passing movement succeeded, and it appeared as though once or twice Graham-Davies might have scored had he taken his pass; but soon the whistle blew and a great game ended. It was an extraordinary match; Oxford had all the worst of it, but used their opportunities; Guy's had all the best of it, but their opportunities were not used so well.

Team.—A. Daneel, H. Graham-Davies, J. Van Schalkwijk, P. K. Albertijn, C. L. Steyn, F. Bekker, E. L. Sprong, R. F. H. Duncan, E. E. Neser, W H. Taylor, E. H. Fouraker, L. K. Watson, G. Zondagh, F. J. Biddle, P. G. Harvey.

GUY'S v. SWANSEA.

An excellent crowd gathered at Honor Oak Park on Saturday, December 3rd, to witness this match. For the first time on record Swansea came to the Hospital ground. The new Grandstand was full, and the ropes lined with spectators three or four deep. Both teams were without their International captains, T. Parker, of Swansea, and W. D. Doherty, of Guy's.

With commendable promptness Swansea trotted out on to the field of play just three minutes after the half hour, and the game commenced in rather strained earnestness. The teams seemed to be feeling each other's strength, and for a while touch finding was indulged in. In the scrummages we were holding our own; at half Bekker was good enough for Tudor Williams. Our men got the ball—Zondagh was hooking well—but Sprong kicked often for touch, while the three-quarters again seemed disinclined to test their powers till play was almost in the visitors' 25. Graham-Davies was an exception to this; he is always game for a go at the line. At length Steyn got away on the left, but could not not pass J. Rees of Wales at full back. Neser next had a shot for goal without success, after which the visitors showed us some pretty hand work. Guy's forwards were putting in their best pace in the loose, and very little headway was made by Swansea's threatened attacks. As half time approached Steyn cross kicked and eventually, from a scrum close in, Van Schalkwijk dropped a very neat goal amid great applause. Soon afterwards the same player made an opening for Graham-Davies, of which the latter took full advantage, going well for the line with success. The kick at goal was almost from the touch line; however, Neser, with great accuracy added a magnificent goal. We had had a following wind with us this first half; and, apparently owing to the referee's watch going wrong, some extra time had been played. It was during this extra time our try and subsequent goal were obtained. This fact caused much controversy.

If my watch be accurate, the second half was also stretched out so as to compensate to some extent any disadvantage Swansea may have sustained. The whole of the latter portion of the game was one of good, keen football; our forwards were a great combined pack and played like a perfect eight. In the tight the control was perfect, in the loose no one spared himself. To the pack goes the chief praise for our victory. There was no scoring this second half, so our total at half time was unaltered at the close. This score might have been added to had our three's dropped some of the everlasting touch finding and had a run or so. The kicking is overdone. Bekker was splendid; Daneel at full back safe and good at touch finding; Fouraker got lamed, but the fine game was played in excellent temper. Both teams were too good to spoil football by hasty temper. The defeated would quite possibly be victors next time, but on this occasion they had to admit defeat by a better side and generously did they admit it. I wish that some of our International Selectors could have seen Bekker, Taylor and Neser, or a Welsh Selector have spotted Duncan. All did well enough to catch the eye of the most exciting critic. Guy's 1 goal 1 dropped goal (9 points); Swansea nil.

Team.—A. Daneel, H. Graham-Davies, J. G. Van Schalkwijk, P. K. Albertijn, C. L. Steyn, F. Bekker, E. L. Sprong, R. F. H. Duncan, E. E. Neser, W. H. Taylor, L. K. Watson, F. J. Biddle, E. H. Fouraker, P. G. Harvey, G. Zondagh.

Marriage.

BULLEID—COOK.—On Saturday, November 19th, 1921, at St. Stephen's Church, West Ealing, Arthur Bulleid, M.R.C.S., L.R.C.P., L.D.S., the son of S. T. Bulleid, Esq., J.P., Torquay, to Kate Gertrude Cook, youngest daughter of the late J. R. Cook, of Eastbourne, and Mrs. Harding, of Bolney, Oxford.

ED.—A. T. R.

GUY'S HOSPITAL GAZETTE.

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Passim.

THESE are the last pages of this volume of the GAZETTE. Before another Passim is written another year will be here—1922—a new year and the GAZETTE's jubilee year. We commenced publication in 1872, and after several early changes we have struggled along through many viccissitudes to this our fiftieth birthday. But in spite of all troubles it is our proud boast that we remain, as we were then, the first of all Hospital journals.

WE take this opportunity of wishing our readers the merriest of Christmases and the happiest and most prosperous of New Years. Those of us who remain in Hospital for Christmas are sure of a merry time; those of you who do not should resolve to spend one day during the week at least with us, if you possibly can, so that you may realise how much the spirit of Christmas still means. You may rest assured of a ready welcome from each and every one of us.

THE Rugby XV. keep us busy chronicling their successes. Each week seems to bring some greater victory than the last. We had all been looking forward to the Cardiff match as one of the most severe of our tests, and when the English selectors chanced to choose four of our best forwards to play on the same day in the English trials, we thought that our chance of victory was gone. But in spite of all such handicaps Guy's succeeded in winning a well fought and well won game by ten points to eight.

We offer our congratulations to our four forwards (R. F. H. Duncan, L. K. Watson, W. H. Taylor, and P. Harvey) who played at Bristol against England, both for their selection and for the strenuous game which, we are told, they played. Two of them (Taylor and Duncan) have been chosen for the final trial on January 7th. We wish them all success.

Though we do not wish to belittle the value of these four players (who all deserved their trials), yet it is an open secret here that the selectors were guided more by an English-sounding name than by true merit. There was such a fuss made in the newspapers when J. A. Krige was given his English cap, that the selectors have since been afraid to give places to South Africans. [They have no such scruples when they are considering the merits of a New Zealander or Australian. If he is worth his place he gets it!. The joke at the Hospital is that we have two forwards, the better one (in the opinion of most men) is an Englishman whose name is South African; the

other, who is very good, but not so good, is a South African—but his name is English. He played in the English trials.

We publish this week two appeals for help, one for the children of Russia, the other for the Viennese professors. We are glad to be able to call attention at this Xmas season of charity and goodwill to the needs of the impoverished population of Central Europe. In these countries money has depreciated so much as to make salaries and savings negligible quantities. The savings of a lifetime might easily be spent without extravagance in a single week. On the other hand, on account of this depreciation, we can, by giving the little we can spare, give much.

A Correspondent, an "Old Guy's Man," raises once again the vexed question of catering in the College. Returning, after an absence of two or three years, he has found the Students' Club in an even worse state than when he left. We at the Hospital have not noticed this great change for the worse. The evolution has been slow and has passed by us unnoticed. Day by day the eggs have got staler, the beef tougher, and the service slower. We have never noticed that things were much worse to-day than they were yesterday. But one coming anew into our midst, who still remembers the comparative comfort of 1919, can thus disillusion us. Yearly we make our protests; we hold meetings, we decide to run the Club ourselves, we tell the Council to give the A.B. Co. notice to leave, then we decide not to change the régime, and we put up with all our discomforts for another year. Meanwhile the eggs get still staler, the beef still tougher and the service still slower.

We have no doubt that this paragraph is but a pure waste of time, print and paper. Even if it does raise a storm of dissent (or of assent), everything will blow over. Much may be said but nothing will be done. When 1923 comes along we will still be eating the same old meals in the same old way.

How much longer are the corridors of the College, its reading and its smoking rooms to be turned into a lurking place for book touts? Quite six weeks ago our privacy was first invaded by a suave gentleman who buttonholed us and asked us if we had had a sample of his new book. He took our orders and his commission and departed—and we rejoiced. But he was soon replaced by another, who (like the poor) is ever with us. We never know where he will be next. He haunts us. One day he stands and gazes pensively into the Externs room with his stock-in-trade laid out upon the windowsill outside, the next he is in the reading room. We meet him in the Medical School, in the Colonnade, in the "Spit." We are almost afraid to go to our own sitting-room for fear he may be there. It is not as if he worried one actively, he only deigns to look, but that is enough. Drawn by his hypnotic eye one is compelled to stop and examine his ever-growing library. He must be doing well, for fresh volumes in gaudy bindings seem to appear every day. We hope he will soon retire and will not trouble to sell his practice, for apart from anything else, it is an uncomfortable strain to have to slink guiltily and craftily past him every day lest he shall take away from us even that money which we have not, And wouldn't it be awful if he took possession of the "Ship!"

Last year we received a few complaints about the inadequacy or the injustice of the reports on the Christmas concerts in the wards, which we published in the first January Gazette. There was great trouble in getting all these reports in in time for publication, and in some cases they were not submitted to the ward

GUY'S HOSPITAL CRICKET CLUB.—FIRST XI., 1921.

(Insets) A. G. ENSOR. G. D. SHAW. R. C. MAY

(Standing) S. ROSE, G. M. STUART. G. CURLE. G. L. SHEARAR. HARRIS.

(Sitting) J. G. VAN SCHALKWIJK. L. B. HELDER. T. WOOLDRIDGE. L. C. WILLIS. F. J. BIDDLE.

sisters for correction. This resulted in several errors being allowed to pass into print. This year we hope our task will be easier, and we earnestly ask all the sisters to find some one of the nursing or the medical staff of her ward who will report her concert for her. We ask her, too, to make sure that we have the reports sent to us already corrected by Monday, Jan. 2nd, otherwise it may be impossible for us to publish a report After this date accounts of ward concerts will be of no use to us. By the end of January Christmas is ancient history, and people do not wish to be reminded of its pleasures just as they have settled down into the workaday groove again.

THROUGH the generosity of the *Daily Sketch* 500 Borough kiddies had a great treat on Wednesday last. Before one o'clock the children, who had all been in- or out-patients of the Hospital during the year, began to gather, happy and excited in the Quadrangle. Thence they were borne 'busload after 'busload away to the Apollo Theatre to a matinée performance of "Where the Rainbow Ends." It was really amusing to watch them go, they were so delighted with the prospect and so eager to get away. If it had been possible the whole five hundred would have crowded on to the first 'bus. As it was the last 'bus went off empty because the previous ones had been overfilled, the kiddies preferring to stand rather than to wait for the next 'bus.

At the end of the afternoon back they came again, singing at the tops of all their voices, to disperse, at the Hospital and clatter off back to their homes to chatter and dream about their wonderful afternoon in Fairyland.

WE cull the following version of an old joke from the pages of the current number of "Punch":—

> "Retired Guy's Nurse desires guest. Pretty village near London. Two guineas."
> *Ladies Paper.*

An Amerian reader would be glad to have a reference from the Retired Guy.

Notice.

RUGBY.

The following letter was sent to Mr. W. D. Doherty, the Guy's Captain, by Two Cardiff Supporters :—

Dear Mr. Doherty,

We are writing to thank you for the excellent display your team gave us on Saturday last.

It was easily one of the best games we have had in Cardiff, this season, and incidentally, Guy's, in our opinion, are the best side we have seen since August last.

We should be glad if you will convey our thanks to every member of the side, particularly Messrs. P. K. Albertijn, Van Schalkwijk, and F. Bekker. We think that it is a very lucky thing for Wales, that these gentlemen are South Africans, and therefore, unable to play for England.

Again thanking you for your very fine exhibition of Rugby Football.

We are,
TWO CARDIFF SUPPORTERS.

Papers by Guy's Men.

C. Worcester Drought, M.A., M.D. Cantab., M.R.C.P. Lond.: The relative incidence of injuries by gunshot wounds to peripheral nerves.—*Journ. R.A.M.C.*, xxxvii., 1921, p. 386.

—— A case of simultaneous involvement of the fifth and eighth cranial nerves.—*Proc. Roy. Soc. Med.*, Sec. of Otology, xv., 1921, p. 7.

Alan H. Todd, M.S., B.Sc., F.R.C.S.: Common disabilities of the feet in children.—*Clin. Journ.*, vol. L, 1921, p. 761.

N. Mutch, M.D., F.R.C.P.: Alimentary infections in chronic arthritis.—*Lancet*, ii., 1921, p. 1266.

J. H. M. Campbell, M.R.C.P. "Some aspects of exophthalmic goitre," Quart. Journ. Med. page 57, October, 1921.

Change of Address.

Capt. R. C. Matson, R.A.M.C. (Half-pay List), 18 Queen Anne Street, Cavendish Square, W. 1.

Arthur Bulleid, M.R.C.S., L.R.C.P., L.D.S., No. 1, Burlington Gardens, London, W. 1.

Interesting Cases in the Wards.

Cases under Drs. Fawcett, Ryle, and Marshall—

Esther	21.	Splenic anæmia.
	27.	Secondary anæmia (?cause).
	28.	Abdominal neoplasm.
	44 (Cot).	Dextrocardia.
Stephen	27.	Pneumothorax.
	32.	Acute nephritis; splenomegaly; ?cirrhosis of liver.
	43.	Acholuric jaundice; splenectomy.
	47.	Cirrhosis of the liver.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

Distress among Viennese Medical Teachers.

SIR,—May I be allowed to encroach on the hospitality of your columns with an appeal for the relief of those who are connected with the teaching of medicine and science in the University of Vienna? In the course of a recent visit to that city I was deeply impressed with the terrible plight in which the salaried professiona classes find themselves, owing to the fabulous rise in the cost of all the necessities of life. This is especially true of all those employed in the study of such subjects as physiology, anatomy, pathology, and in fact of all engaged in medical education. with the exception, perhaps, of a few to whom private practice is a source of income. To-day many teachers get less pay than is earned by a porter or tram-car driver.

Relief work is being undertaken by the Friends' Emergency and War Victims' Relief Committee, of 27, Chancery Lane, W.C. 2. Any contributions that may be received from Guy's may be ear-marked specially for the relief of those connected with the teaching of science and medicine in Vienna. When it is realised that the pound sterling in Vienna is worth between 25,000 and 30,000 kronen (pre-war value £1,000 to £1,250), it will be understood that even a small sum in British currency represents a great deal to the impoverished Austrian.

Subscriptions may be sent direct to the Committee at the above address, or to me at Guy's Hospital.—I am, Sir, yours, etc., J. J. CONYBEARE.

Guy's Hospital, S.E.1.
Dec. 16th, 1921.

Presentation to Mr. Lane Roberts.

DEAR SIR,—May I, through your columns, thank those past and present members of the Anatomical Department for their extremely kind and gratifying presentation to me. It was a very great privilege to be able to spend that year—one of the happiest of my life—as Demonstrator in the Dissecting Room among such a fine body of men. Further added to it was the very great pleasure of working under the inspiring example and brilliant teaching of Professor Johnston, with on one's right hand that stout henchman Hancock, one of the real indispensables of the Hospital entourage. —Yours, &c., C. S. LANE ROBERTS.

The Maternity Hospital, Leeds,
December 20th, 1921.

The College Catering.

DEAR SIR,—On returning to Guy's after an absence I am appalled at the wretched and deplorable conditions at present existing in the Dining and Smoking Rooms of the College. The rooms are dirty and greasy. The food is of second quality, improperly cooked, and more expensive than the same class of food elsewhere. Surely it is time that the present men in the College should move to abolish these ignominious conditions unworthy of the traditions of Guy's.—Yours, etc., OLD GUY'S MAN.

Guy's Hospital, S.E.1.
December 20th, 1921.

Save the Children Fund.

DEAR SIR,—Just four years ago I was lucky enough to be sent from the heat and boredom of Mesopotamia to new adventures in Persia. The country we passed through had been stripped bare by the Russian army, and there was so little security that it had hardly seemed worth while to plant any crops.

Many villages were deserted and in ruins, and even in the larger towns thousands were dying of starvation. Each time one visited the bazaar one found more corpses, and in the country there were the bones of men who had fallen by the roadside and been eaten by jackals.

The first morning in camp a dying baby, who had been found in the fields near by my servant, was brought to my tent, and soon there was hardly a platoon in the force without its adopted children; and some of these lived with the men for many months.

It was as natural for everyone to give what help he could, as it is for us now to do any of our usual daily occupations. The greatest personal effort which I saw was when an American lady doctor and her husband took nearly seventy starving children into their own home. It was wonderful to see the change in them six months later. Only fifty survived, but they had become healthy and happy and were more like English children than any other I saw in the East.

To-day it is the turn of Russia, and these same conditions have arrived over a much larger area. It is not the fault of the Russian children—perhaps not altogether the fault of the Russian peasants.

We all know the difficulty and expense of saving one child with pneumonia from death, or one child with rheumatic fever from a damaged heart. Fortunately it is much easier to save a child who is dying of starvation.

For one hundred pounds, the Save the Children Fund will start a new kitchen, and feed a hundred children for five months, after which the greatest need should be over. The kitchen will be named after the donors. If those who are connected with the Hospital could raise this money, such an action would be in close sympathy with the spirit

of our Founder—Thomas Guy—especially now that our Xmas duty to our own children of the Borough has been performed.

Many Guy's men have already given, and I shall be pleased to receive subscriptions from any others who would care to do so. I have sent a first instalment so that the work may not be delayed.

If there are any men who would like to give, but have doubts about the good use of the money, or about the possibility of its being used to maintain the present regime in Russia, I shall be pleased to give them further information,—I am, Sir, yours,

J. M. H. CAMPBELL.

Guy's Hospital,
Xmas Eve.

DEAR SIR,—In the land of what I am pleased to call the home of rugby football, they have certain local laws which, I think, might be copied with advantage by the English Union or clubs.

In New Zealand (!) it is the custom in all games of any importance for the time to be kept by a timekeeper in the stand (if any), or at least by someone on the touch line. He has no distraction (or at least *should* come unaccompanied) yet has leisure to accurately take account of, and allow for, the time taken in minor stoppages. Maybe a club with a five guineas "sub." would provide a referee's watch. When the arranged time has been played he rings his bell, and the next time the ball goes into touch the referee blows "half-time," or "no side" as the case may be. Besides many minor advantages this plan diminishes the possibility of so great an error as the one which occurred during the Swansea match.

The rule that the ball must be thrown in at least five yards from the line out does away with some of the dullest play from both the players' and spectators' points of view. It also facilitates the work of the referee. At present, when in one's own twenty-five, and often when not, it appears to be the custom in England for the half to throw the ball in only a few feet. Then a mass of gibbering and sweating humanity amuse a few of the less enlightened spectators by treading on each other's faces, whilst the ball almost invariably goes into touch again. In most grounds in N.Z. an interrupted line is drawn parallel to, and five yards inside the touch line. In a "line out" no player may stand outside of this five yards line, and the ball is not in play until it has been thrown over this line. This five yards margin gives the necessary spare space for odd skirmishing without making it inevitable that the ball go into touch.

The innovation of numbering the players correctly (copied, I believe, from the N.Z. idea of lettering the players—though the fashion may have been in vogue in England in byegone years) seems to have been received with a certain amount of popularity, but surely it is no improvement to give the players one number on their jersey and another on the programme. As a half-time distraction to see how many are numbered incorrectly, it may have its attractions.

"QUANTI EST SAPERE."

Getting It Across.

People in the theatrical line have their anxious moments when delivering something new to the public. Whether the material is good or bad on paper, its success depends almost entirely on the way it is delivered.

When their efforts are well applauded, an expression they sometimes use is "They have got it across"—the footlights being the objects to cross—the expression originated, I believe, with the music-hall artist when the gallery took up the song.

In Kipling's "A Diversity of Creatures" the actress who sang the ditty—

> "The Village that voted the earth was flat,
> Flat as my hat,
> Flatter than that,"

and got the whole house to roar it, is shown behind the scenes exhausted with her efforts, being assured by the author that she has "got his song across."

The article which appeared in a recent number of the GAZETTE, "The Folly of Overstatement," suggests that there may be something to be said against understatement, and the lack of enterprise in those who never get outside the plain statement of a fact.

Many have knowledge to impart or something to say, but not all have the style of delivery necessary to make their efforts a success. They do not get it across.

In no way does this apply more than in the case of the after-dinner speaker; unless he deals out something poignant at once, the attention of his hearers will wander. The speaker realised this who began, "Gentlemen, Physiologists tell us where we came from, Theologists tell us where we are going to; but all I know is I'm darned glad to be here to-night."

The value of contrast is appreciated. In Miles' and Thompson's Surgery, dealing with the reduction of dislocations in general, we read, "No amount of mechanical force will compensate for a lack of anatomical knowledge." The contrast in this case shows the superior excellence of the one to the other, the anatomical knowledge to the mechanical force, and the picture of the perspiring individual with his

foot, or later on, both feet in the axilla, is recalled in its most painful colours.

Mark Anthony's opening words were, "I come to bury Cæsar, not to praise him." He had to go carefully to work, as the crowd were still under the effect of the dope dealt out by Brutus. The contrast in the two methods of dealing with the late Julius Cæsar is striking, the safe one of arranging for the burial, and the very risky one of making suggestions for a favourable obituary notice. Mark Anthony knew the value of this in getting the attention of the mob.

A recent article in the *Times* pointed out the series of clever contrasts in the clown Grock's performance, which made it so successful. The immensely baggy trousers and then the extremely tight ones; the outsize in violin cases containing the smallest of violins; his suggested inability to play and his skill as a pianist when under protest he does eventually make a start.

A pointed saying is always helpful. A few weeks ago an inquest was held on a boy who was knocked down by a vehicle while running after another vehicle. Those concerned were considering how much was the fault of the boy, how much the driver of the vehicle was to blame, and whether anything could be done to prevent boys running after vehicles. Dr. Edwin Smith, a London coroner, helped them out by saying, "The boy has yet to be born who will not run after a vehicle," and the remark appeared in one of the evening papers under the heading "Sayings of the Day." Had he said, "Boys always will run after vehicles," the remark would probably have passed unnoticed, although the meaning is the same.

The misapplication of terms or expressions in common use is often effective, but not to be recommended, as the result may be a burlesque. For example, in the *Times* personal column a person applying for a post advertised that his "Brains were in brand new condition—owner has never used them." The notice attracted by this might be the entire success of the advertisement.

An example of this sort of thing occurred in the political world. It is recorded that Mr. A. J. Balfour was once confronted with the unpleasant necessity of publicly calling a man a liar. He did it in a very polite way, but with a maximum effect.

Some disturbance occurred in Ireland at which a Member of Parliament was known to have been present and for which he was considered to have been responsible. He denied having been present in Ireland at the time.

Mr. Balfour said, "Regarding his own whereabouts on this particular occasion, I think the Hon. Member has been misinformed." E. R. BAILEY.

A Case of Gastro-jejunal Ulcer treated by Jejunostomy.

C. W., æt. 36, a lorry driver, admitted 6th August, 1921. Nine months before admission, following a brief history of indigestion, he had an attack of severe abdominal pain and vomiting. He was operated upon in Luke Ward, and a perforated duodenal ulcer found. This was closed and a posterior gastro-jejunostomy performed. Since then he has been almost free from gastric symptoms.

For a fortnight before admission he complained of a feeling of fulness after meals, but no pain. A week before he was admitted he had one morning a feeling of faintness and giddiness. This was followed by slight diarrhœa in which typical tarry stools were passed. Four days later he had a copious hæmatemesis, and was admitted shortly afterwards.

He was treated by sedatives and rest for a few days, during which he was starved. A test meal was then done and showed an emptying time of two and a quarter hours. There was much regurgitation of bile and the free acid was constantly rather low. An attempt was then made to commence the routine peptic ulcer diet, but five days after admission (10th August, 1921) he again had an extensive hæmatemesis. This was repeated three days later in spite of treatment by morphia and alkalies. After this third hæmatemesis his hæmoglobin was found to be about 30 per cent. His temperature began to rise, and it was then noticed that he was developing parotitis on the left side. On the 22nd August, 1921, he had another hæmatemesis which was very profuse. His hæmoglobin had now fallen to 20 per cent.; clotting time was within normal limits (1 min. 37 secs.). It was now decided to operate and transfuse him at the same time, the opinion being that he had a gastro-jejunal ulcer.

The stomach was exposed via a paramedial incision and the scar of the duodenal ulcer discovered. The pylorus was quite patent. No sign of a gastric ulcer could be noticed externally and the gastro-jejunostomy stoma appeared quite normal.

The stomach was then opened and a small breach in the mucous membrane of the stomach on the posterior wall near the pylorus discovered. This was oozing blood freely, and it was considered that it might be the cause of the hæmatemesis and that he was suffering from an acute ulcer at the present moment. The stoma of the enterostomy was carefully examined and no sign of ulcer could be discovered there. The bleeding point was surrounded by two tiers of inter-locking stitches so placed as to entirely cut off the blood supply about this spot. The stomach and abdominal wall were then sutured. During the operation about 500 c.c. of blood were given by the

citrate method. He stood the operation well, and as no chronic ulcer was found, an attempt was made to return him to a diet less strict than the routine peptic ulcer diet. He improved remarkably for a week, and his hæmoglobin increased to about 27 per cent. The parotitis also disappeared.

A week later, however, he again had hæmatemesis. Next day on the 30th of August, he had another. Next day he was transfused and 300 c.c. of blood given. Strict precautions to ensure rest to the stomach were taken. For three days rectal feeding alone was used and then citrated milk.

On the 4th of September he again vomited blood, but only a small amount. His hæmoglobin now was found to be 15 per cent. Twice during the next three weeks he complained of a feeling of gastric distension, and his pulse began to rise. On both occasions treatment as if for hæmatemesis was carried out, and a few days later the stools appeared black and tarry and contained much blood.

On the 23rd he again showed signs of hæmorrhage, so his stomach was washed out and blood clot removed. Thrombo-plastin (2 c.c.) was then injected. Next day he was again transfused, 300 c.c. being given. His hæmoglobin was now as low as 10 per cent.

On the 27th there were signs of further bleeding, and morphia and hæmoplastin were given. No blood was vomited.

October 3rd he again vomited blood in quantity. His stomach was washed out and intra-muscular calcium chloride given. Next day transfusion was again performed. Dr. Hunt and Mr. Rowlands held a consultation and decided, as a last resort, to rest the stomach entirely by performing a jejunostomy. This was done on the 6th. The jejunum was opened near the duodo-jejunal flexure and a soft catheter inserted. The tube was then buried in the jejunal wall for a distance of two inches by a stitch which brought the jejunum on either side of the catheter together, thus forming a tunnel, one end of which entered the bowel and the other end opened externally.

He withstood the operation remarkably well, and for the next few days was given rectal feeds, while small amounts of water were given by the jejunal tube. A continuous drip of citrated milk was commenced on the 8th and taken very well.

All went well until the 14th, when the tube became blocked. It was withdrawn and a fresh one inserted, and food was again given. That night he complained of pain in the abdomen and there was general rigidity and tenderness. His pulse began to rise, and he died next day.

At the autopsy it was found that the jejunostomy had perforated into the general abdominal cavity. The perforation was opposite the point where the tunnel down which the catheter passed entered the lumen of the bowel and was an inch and a half from the external opening of the catheter, and it was apparently due to deficient formation of plastic peritonitis. It was also obvious that the latter part of the last feed of milk had been given into the peritoneal cavity and had produced the peritonitis which caused death.

In the stomach, signs of the previous operation were scarcely demonstrable. At the gastro-jejunal stoma, however, was an ulcer which was obviously partially healed. There was no other evidence of a bleeding point. The lessons which one can draw from this are the danger of a gastro-jejunal ulcer following an operation for gastric or duodenal ulcer. Latterly this sequel has been estimated as occurring in about 10 per cent. of gastro-jejunostomies. Secondly, it shows the difficulty of operating simply for the control of hæmorrhage, as the possibility of the previously found bleeding point being due to trauma at operation was never entirely excluded (while, although the gastro-jejunal ulcer was not found at operation, its presence may possibly have been overlooked). Thirdly, the function of the jejunostomy in resting the stomach and allowing the ulcer to heal seems to have been adequate, and except for the unfortunate accidental perforation all might have gone well.

I am indebted to Dr. Hunt for permission to publish this case.

Specialities.

THE "G.N." MOTORS, Ltd., East Hill, Wandsworth, S.W. 18.

It is now some twelve or thirteen years since the originators of the "G.N." Cars experimented with a light-weight chassis and a motor-cycle engine, and step by step they have evolved a car which is guaranteed to do 60 miles to the gallon, and holds the half-mile record at over 88 miles an hour.

The "G.N." two-seater Car is a champion hill-climber with an engine (90° air cooled twin) which is vibrationless.

It is of handsome design, one of the most comfortable two-seater cars obtainable, and is offered, with full equipment, at a price which brings it within the reach of purchasers with the most modest income.

The "G.N." Motors, Ltd., will be pleased to arrange trial runs at any time with those interested.

Notice.

THE VARIVANE CO., 10, Finsbury Square, E C.

In referring to the appliances supplied by the above Company in our last issue, we should have given their address as 10, Finsbury Square, and not 4, Old Street.

La Nuit Parégorique.

(Being a nightmare consequent upon reading advertisements in magazines.)

Of all the pills that flesh is heir to,
To sooth our multifarious ills;
None (so the papers say) compare to
Those wondrous sperules *Pogg's Pale Pills.*
If horrid pangs assail my middle,
Or pains that stab, or aches that gnaw so,
They bid me wrap some *Wadorhidol,*
Just where it hurts, around my torso.

Or if my nerves are getting rummy,
If I have hardly strength to speak,
Or if my liver, kidney, tummy,
Lung, colon, spleen, or heart is weak,
A *Dry-Cell Belt,* as all bear witness,
Will make me buoyant, youthful, glad,
Emitting sparks and rays of fitness,
(At least, according to the ad.)

If nineteen doctors fail to cure me,
And I am very, very sick,
One dose of *Swankoids* (they assure me)
Is pretty sure to do the trick.
When I'm alarmed because I'm plumpish,
"Antarbuck" takes away my fat.
Nay, more, from being somewhat lumpish,
It makes me skinny as a rat.

O ye who've myxœdema, gout,
Yaws, baldness, corns, or tonsillitis;
All ye who e form needs padding out,
And ye whose waistcoat far too tight is;
Ye patient sufferers from eclampsia,
Sprained wrists, and goitres, gumboils, tumours,
Who suffer from our fogs and damps here,
From piles, sprue, squint, or merely rumours;
Whate'er your ailment, shun the dopes,
Doctors prescribe and chemists mix here,
They're wrong. On one thing build your hopes,
Pantherapon's the true elixir!

Vacuous Verses.

(With apologies to C.S.C.)

I.

The Surgeon strode thro' the Theatre door,
(Sutures and Swabs and a roll of Gauze)
His apron trailing the spotless floor,
And a yashmak veiling his classic jaws.

The Dresser stood with an anxious sigh,
(Sutures and Swabs and a roll of Gauze)
Looking a needle straight in the eye,
With a piece of thread in his half-washed paws.

The Sister gazed thro' the window pane,
(Sutures and Swabs and a roll of Gauze)
Bewailing the hypertonic rain,
For a new frock lay in her chest of drawers.

The Ward-Clerks lounged at the table-side,
(Sutures and Swabs and a roll of Gauze)
Watching the Surgeon's knife divide,
And sagely nodding at every pause.

The Patient received in course of time,
Sutures and Swabs and a roll of Gauze,
Thro' a slit in his Para-Rectal Line,
According to all the Surgical laws.

Did the Patient live? Did the Patient die?
(Sutures and Swabs and a roll of Gauze)
Do you not know? well, neither do I,
But I think these verses deserve applause.

II.

Impression.

I brought a stranger to our gates,
Dreadfully dull was he;
Truly a man of no account,
With a crude mentality.

I decked him out in a brand new hat,
And a coat of the latest style;
I taught him to walk distinguishedly,
With a very professional smile.

I ushered him thro' the Colonnade,
Each Porter touched a hat;
Ward-Clerks and Dressers stared and said,
"Now who the deuce is that."

I took him along to every "Op.,"
At each he caused a stir;
His opinion every Surgeon craved,
And even the Sisters called him "Sir."

* * * * * *

I haled a savant from the North,
A man of integrity;
Skilled in the art of healing sick,
And a Master of Surgery.

I found him a pair of flannel bags,
With thin atrophic knees;
An old tweed coat and a khaki shirt,
And I dressed him up in these.

I bade him walk in the Colonnade,
And mingle with the rest;
The busy throng scarce noticed him,
They only know the best.

I showed him into a Theatre,
To the best case of the day;
But little he heard and less he saw,
For they elbowed him away.

Stones in the Common Bile Duct.

CLINICAL LECTURE BY MR. R. P. ROWLANDS.

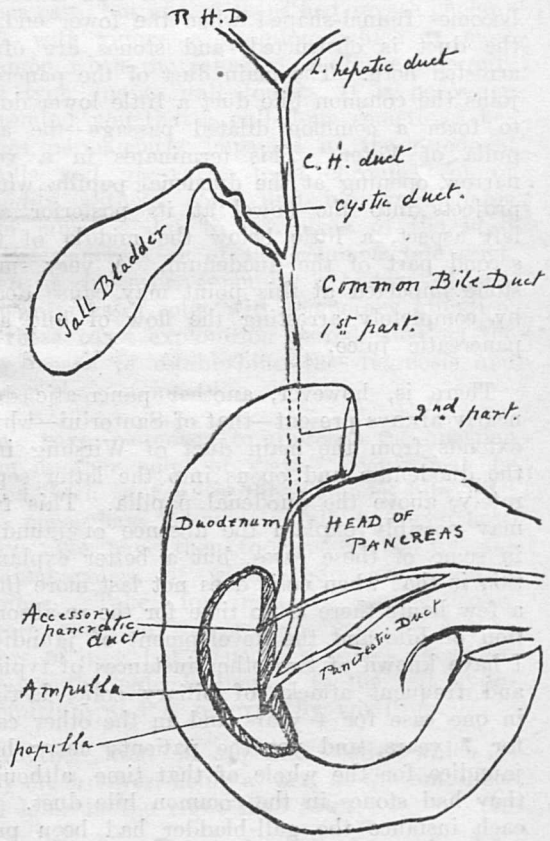
GENTLEMEN,—This lady, aged 68, had a stone removed from her common bile duct 10 days ago. She had had many attacks of severe pain in the right hypochondrium during the last 20 years, these attacks of colic lasting sometimes for three or four hours and often recurring for three or four days. Injections of morphia were frequently required to relieve the pain. She vomited in most of the attacks, but never had jaundice. She had much flatulent distension of the abdomen. Four years ago I removed her gall-bladder, which was full of stones, but I was unable to find any stone in the common bile duct. While still in Hospital she had an attack of pain which was not considered to be serious at that time.

Afterwards the patient remained well for three years, but during the present year she has had many attacks of severe pain just to the right of the epigastrium and nearer the middle line than in the former attacks. It radiated through into the back. None of these attacks lasted longer than three hours, and she was never jaundiced either at the time or afterwards. Once or twice she noticed pale-coloured stools. The attacks of pain were becoming more frequent and severe and the patient was losing weight. Diet had no effect on her symptoms and alkalies and belladonna failed to relieve them. There was distinct tenderness over the common bile duct. At the operation, 10 days ago, a very small, round stone, half the size of a pea, was removed from the common bile duct. This was not facetted from contact with another stone.

It is quite possible to over-look such a small stone, for, even at this operation, when a stone was expected, I could not feel it on careful palpation of the common bile duct. This duct, however, was dilated above the duodenum. I opened it and passed a probe down, towards the duodenum. It would not enter the latter and just behind its bulbous head I found this tiny stone. With some trouble I was able to back it up, along the side of the probe, and get it out from the first part of the duct. The chief reason why I did not feel it at first was because I did not go low enough. It was in the ampulla of Vater, and such a small stone is very difficult to feel through the pancreas and duodenum at this spot.

A tube left in the common bile duct after the operation came out to-day and a little bile still issues from the wound, which is otherwise firmly healed. The incision is that of Kocher, which I believe to be the best for thoroughly exposing these parts. The rectus and its sheath are completely cut across, 1 inch below the right costal margin. I expect the patient will be able to go home, with the wound well healed, in another week. This will be $2\frac{1}{2}$ weeks after the operation.

It will help us in considering this question to study the anatomy of the bile ducts (see Fig.). There are right and left hepatic ducts,



each three-quarters of an inch long, and joining to form the common hepatic duct which is $1\frac{1}{2}$ inches long. Stones very rarely form in these ducts but may be displaced upwards into them from the common bile duct. The cystic

duct is also 1½ inches long. It is often tortuous, its lumen is very small and its mucous membrane is raised into a spiral valve, carefully described by Heister. This makes it very difficult for stones to leave the gall-bladder and the large majority of gall-stones never reach the common bile duct at all, so that jaundice is only an exceptional sign of gall-stones. The cystic and common hepatic ducts join to form the common bile duct, which is 3 inches long. This duct, with which we are especially concerned to-day, is divided into four parts, the first being accessible in the free edge of the foramen of Winslow, where it lies in front and to the right of the blood vessels, the second being behind the first part of the duodenum and then in, or behind, the head of the pancreas, close to the duodenum. This part does not easily dilate and therefore becomes funnel-shaped when the lower end of the duct is obstructed, and stones are often arrested here. The main duct of the pancreas joins the common bile duct a little lower down to form a common dilated passage—the ampulla of Vater. This terminates in a very narrow opening at the duodenal papilla which projects into the bowel at its posterior and left aspect, a little below the middle of the second part of the duodenum. A very small stone impacted at this point may cause death by completely arresting the flow of bile and pancreatic juice.

There is, however, another pancreatic duct nearly always present—that of Santorini—which extends from the main duct of Wirsung into the duodenum and opens into the latter separately, above the duodenal papilla. This fact may possibly explain the absence of jaundice in some of these cases, but a better explanation is that when colic does not last more than a few hours there is no time for the re-absorption of bile and the development of jaundice. I have known of two other instances of typical and frequent attacks of biliary colic, lasting in one case for 4 years and in the other case for 7 years, and yet the patients never had jaundice for the whole of that time, although they had stones in the common bile duct. In each instance the gall-bladder had been previously removed so that the pain could not have been in the gall-bladder or cystic duct.

Referring again to the case of the lady we have just seen, it is a question whether that stone was overlooked at the original operation or whether it has formed since. The chances that it was overlooked are very many for the formation of a stone in the common bile duct is one of the rarest things possible. The patient had colic while still in Hospital and I believe the stone was in the duct at the time of the original operation. I have no notes made at the time, for it was done in 1918, when time available for making such notes was scanty, owing to the war, thus I do not know whether I passed a probe down the common bile duct or not. At the time of the second operation, when I had backed the stone by the side of the probe, it shot into the little stump of the cystic duct which I incised for its removal. It is possible that the stone may have formed since in this cul de sac, and this possibility makes it necessary to remove the whole of the cystic duct when performing cholecystectomy.

Symptoms.—Biliary colic is the most severe of all the colics. That due to stone in the common bile ducts is situated just to the right of the ensiform cartilage and extends towards the umbilicus and through into the back. Patients suffering from it can hardly keep still; they become pale, sometimes shiver and often feel faint. Morphia is often necessary to relieve the pain which may last any time, from a few minutes to three or four days. Colic is, however, sometimes entirely absent and is replaced by intense nausea. Jaundice is a prominent symptom, but is not invariable, for a stone may not be impacted in the common bile duct long enough to allow absorption of sufficient bile to cause jaundice. In many instances both colic and jaundice are intermittent owing to the ball-valve like action of the stone which often falls back on account of increasing distension and dilatation of the duct, and thus temporarily relieves obstruction. Repeated vomiting is a frequent symptom; fever and shivering are not uncommon and are due to infection of the bile ducts which may be transient or last indefinitely. This ascending cholangitis, which may be either infective or suppurative, may give rise to a remittent or intermittent type of fever, usually associated with rigors, and is a serious symptom (Hepatic intermittent fever of Charcot).

Signs.—You will notice certain signs such as jaundice, but this may be easily overlooked at night. It is best and most certainly detected in the conjunctiva. Bile pigments are found

in the urine, and there is some flatulent distension of the abdomen and generally marked local tenderness over the common bile duct, just to the right of a line extending from the umbilicus to the ensiform cartilage. For this examination it is necessary to relax the abdominal muscles thoroughly by bending the knees while the patient is lying on her back, in a comfortable position, with the head flexed and supported by a pillow.

Diagnosis.—As a rule the history of previous attacks and the association of intermittent or remittent jaundice with paroxysms of colic make the diagnosis of stone in the common bile duct very clear and easy. In catarrhal jaundice the pain is trivial and the jaundice slight, of short duration, and it generally occurs in younger people. Small hydatid cysts passing down the common bile duct may give symptoms indistinguishable from those of gall-stones; similarly blood-clot in the common duct —especially after operations on the bile ducts— may be very misleading. Obstruction of the common bile duct by pressure from without or by tumours, or stricture of its wall, will commonly cause jaundice, but this rarely sets up typical biliary colic and the jaundice is seldom intermittent or remittent, like that due to stones, but is progressive and generally deep. Unlike gall-stones, these conditions usually give rise to enlargement of the gall-bladder, often with some enlargement of the liver.

It is well to enumerate some of these causes of jaundice:—

(a) External tumours or inflammatory swellings pressing on the bile ducts, such as carcinoma of the head of the pancreas, malignant glands in the portal fissure, aneurism of the hepatic artery, chronic pancreatitis, pancreatic cyst, hydatid cyst and advanced tumours of the stomach, liver or right kidney.

(b) Diseases of the wall of the bile duct, such as carcinoma of the common bile duct or common hepatic duct, of the ampulla of Vater, or at the duodenal papilla, papilloma of the common bile duct, and stricture of this duct following gall-stones or operations for their removal.

New growths of the liver, either primary or secondary, and cirrhosis of the liver, often give rise to chronic jaundice, but this is neither intermittent nor deep and the liver is generally enlarged, hard and palpable. Although pain may be severe with these conditions it rarely occurs in paroxysms like biliary colic. They are also associated with marked wasting. With cirrhosis there is generally, but not always, a history of alcoholism and the characteristic facial appearance with morning sickness, hæmatemesis and ascites.

Obstruction of the common *hepatic* duct, especially when it is due to carcinoma of its wall, gives rise to progressive, deep jaundice which is not associated with enlargement of the gall-bladder. This makes it difficult to distinguish from obstruction of the common duct due to stone, but paroxysmal attacks of pain are generally absent. I have operated, during the last few years, upon two patients suffering from primary carcinoma of the common hepatic duct. Colic was not present in either case, but one of them had severe cholangitis with rigors, a symptom which is most common when the jaundice is of the intermittent type due to gall-stones. It is necessary to remind you that a gall-stone sometimes becomes permanently impacted at the duodenal papilla and gives rise to a chronic type of jaundice without colic, and indistinguishable from jaundice due to carcinoma of the head of the pancreas or of the common bile duct. There is, however, generally a history of previous attacks of colic, with temporary jaundice. In these cases exploration is indicated as the only means of establishing the diagnosis and saving the patient's life.

We have, moreover, to approach the question from another point of view. People may be found with stones in the common bile duct who never have jaundice at all, but who have colic. We have then to consider all the abdominal colics, of which there are quite a number. Take, for instance, gastric colic. Severe pains in the stomach may be due to errors of diet, but gastritis is easily diagnosed because the pain is limited to the left hypochondrium and is relieved by vomiting.

Another kind is appendix colic, which is very much lower, being at first at the umbilicus and later in the right iliac fossa.

Renal colic shoots through from the loin down into the groin or scrotum; it does not localise itself in the right hypochondrium and it is not so severe as gall-stone colic. Repeated examinations of the urine, radiography and cystoscopy generally clinch the diagnosis.

Pancreatic colic, caused by stone in the pancreatic duct, is median and epigastric and may be mistaken for gall-stone colic, but it is extremely rare. These calculi, consisting chiefly of carbonate of lime, may show in the X-ray plate, whereas gall-stones in the common bile duct very rarely show up, because they are neither large nor opaque enough to cast a shadow.

Intestinal colic, due to growth of the colon, may closely simulate biliary colic, but it is not associated with jaundice, but with definite intestinal symptoms and signs.

Indications for operation for gall-stones in the common bile duct.—Are there any dangers in leaving stones in the common bile duct? Yes, for the health is bound to deteriorate, the patient never knows when an attack may come on and is unable to lead an active life. Also acute infective pancreatitis may develop and rapidly lead to death. In nearly every instance of this disease there are gall-stones in the common bile duct. Again, ascending inflammation of the bile ducts may ensue, and cause death or add greatly to the risk of operation. In some cases portal pyæmia develops and this is invariably fatal. Moreover, cancer may result from the chronic irritation of gall-stones.

Gall-stones in the common bile duct sometimes pass, but if the attacks are repeated it is well to operate. You must divide the cases into two classes. First there are those in which the attacks are of short duration and the jaundice lasts only a few days. You can deal with these at any time, there is no great hurry. You can choose your time for operation, and when there is fever, always select an interval between the attacks. There is the other class of case in which the stone is impacted and firmly fixed in the duct. It will not move and gives rise to chronic jaundice. In such a case an operation must be done during the attack in order to save life. The sooner it is done the better, for long-continued jaundice causes anæmia and wasting, and lowers the coagulability of the blood so that the risk of hæmorrhage increases with delay.

Certain details of the operation I may mention as important. The first is to get good and easy access to the common bile duct and there is no incision to equal Kocher in this respect. The abdomen is then rapidly explored and all the biliary apparatus very carefully examined before deciding on the plan to be adopted. If a stone is found in the common bile duct it is pressed back into the first part of the duct before the latter is incised and the bile let out, for this makes it much easier to displace the stone into the more accessible part of the duct. In the large majority of cases the calculus can be pushed back from the lower part of the duct and in this way the need of opening the duct behind the duodenum or of opening the duodenum itself is avoided. If the stone is firmly impacted and will not move the common bile duct is opened above the duodenum and an attempt is made to remove the stone with a gall-stone scoop and forceps. Failing this, either a retro-duodenal or trans-duodenal operation has to be adopted. The latter is reserved for stones impacted in the ampulla or at the duodenal papilla. A longitudinal incision is made in front of the duodenum and the stone removed, after incising the mucous membrane in front of it The wound in the duodenum is then closed by two layers of cat-gut sutures, in such a manner as to make the scar transverse to the duodenum. In this way the lumen of the bowel is not narrowed but widened. In every case of suspected stone in the common bile duct a suitable olive-headed probe must be passed up and down the ducts, and through the papilla into the duodenum, and in the majority of cases the finger can and should be introduced into the common bile duct to make sure that no stone is left behind.

After opening the common bile duct, it is wise to drain it. A small, long, rubber tube is used and passed up towards the common hepatic duct. Two side holes are made near the end of the tube so that some bile still passes down into the duodenum. The tube is fixed in by a fine cat-gut suture passed through the peritoneal covering of the duct. This allows earlier and easier removal of the tube. The parietal wound is accurately closed in layers and the end of the tube is placed in a bottle at the side of the patient. This allows her to get up after a few days.

Pass List.

University of Cambridge.

M.B.

R. B. P. Lansdown.

Guy's Employees' Association.

"Some Employees I have known and a Few Others."

An Address by Mr. MONTAGU F. HOPSON, November 30, 1921, under the Presidency of Professor T. B. JOHNSTON.

Mr. Dean and Ladies and Gentlemen,—When I was on duty in the Dental Department the other day, an old man doddered into the gas-room, and with the assistance of the nurse seated himself in the chair. I looked down at him and said, "How old are you, daddy?" He looked up at me for a moment and replied, "Well, sir, I don't think there's very much between us, you know I've turned seventy-two?" If that old man's estimate of my age had been correct, there might have been some excuse for my accepting your kind invitation to talk to you to-night for a short while about some of the employees that I knew at Guy's many years ago, and certainly I should have had a richer field to till. As it is, my recollections only go back some thirty-three years, which is but a very brief span in the history of an Institution about to celebrate the bicentenary of its foundation.

It was a very cold morning, early in January, 1889, that I slipped on a cabbage leaf and nearly lost my feet in St. Thomas's Street, before turning into the front gates of the Hospital for the first time in my life. I naturally stopped to have a look at the statue of Thomas Guy in the front quadrangle. There was a pewter pot on the top of his head, a garland of holly round his neck, and ashes of a recent fire at the base of the pedestal on which he stood. That pot, that garland of holly, and those ashes, I afterwards found, were conclusive evidence as to the newness of the year. I ascended the colonnade steps, and at the Lodge I was received by old Joseph Parsons, the porter. I always liked Parsons. He took off his hat and very courteously gave me the information I sought. Parsons came to Guy's in 1878, having done 21 years' service in what is now the IVth Hussars. To begin with, he had charge of what was known as the back gates. For in those days, at the end of the Broad Walk through the Park there were some large gates which led into Newcomen Street, with the porter's lodge by the side. Parsons had charge of those gates, and then he was promoted to the front lodge. He used to live in a little house in St. Thomas's Street, next door to where the Chaplain then lived. He had a series of grandchildren who lived down in the country and used to come periodically and stay with their grandparents, and when they came Mrs. Parsons would trot them in to me to have their teeth looked after. After being here many years Parsons unfortunately contracted scarlet fever, and never recovered really from that attack. Eventually, in 1895, he retired, to the regret of everybody, and went down to live at Midhurst (Surrey).

The information that I sought from Parsons, when I first saw him, was as to the whereabouts of the Medical School Office. There I had an appointment with Dr. Perry, who was then Dean. The Medical School Office was, as Parsons told me, down the steps at the end of the colonnade, and the sixth door on the left hand side. That, of course, was next to the Dispensary. Just as I was about to enter the door of the Medical School Office, I looked across the way and saw a figure in uniform. At first I thought he was a guard on the South-Eastern Railway. He wore a peaked cap, and a cross-belt, and I noticed that he had a medal on his breast and that his legs were a little bowed. It was Hession, the old Commissionaire. Hession had charge of the Student's Cloak Room. At that time the Students' Cloak Room was situated in the block of buildings on the right hand side, at the end of the Broad Walk through the Park, opposite the Dispensary. That block of buildings, consisting of two storeys, housed the Museum, excepting certain anatomical specimens, which were kept in the long gallery where the Biological Department now is. There also was the Anatomical Theatre. Upstairs were two class rooms which contained a few specimens, also the Physiological Department, quite a small affair in these days. The only part now remaining is the Dissecting Room and the buildings attached thereto. These buildings were pulled down when this block in which we now are was erected. May I remind you that when this block of buildings was opened the ceremony was performed by the then Prince of Wales, who afterwards became King Edward VII. When the Nurses' Home was built the then Prince of Wales opened that, and he is now King George V. The Massage block, would have been opened the other day by the present Prince of Wales, illness unfortunately prevented, and we welcomed the Duke of York in his stead.

Hession was an advanced socialist for his time, though he would not have been thought much of a socialist to-day. He used to regale us youngsters with tales of the members of the Staff whom he had known as students. He kept a list of the men going up for the preliminary examinations in anatomy and physiology, and he was a very good tipster, as to who was going to get through and who was not. He was an old Naval man, and his bowed legs were due to an accident he met with on board ship. Hession was a commission agent as well as a Commissionaire. He sold old books and microscopes on commission. Further, he was a connoisseur and

collector of unclaimed goods. I always noticed that he became very attentive to one's needs as the year drew towards its close. Hession served well and faithfully for a great number of years, and then retired on a well-earned pension.

When I entered the Medical School Office to keep my appointment with the Dean I found inside Mr. Wells, Morley, the janitor, and a newly-arrived clerk whose name was Croucher. Most of you will, I think, remember Mr. Wells. He was a truly remarkable man. He was short rather than tall, and he had keen, piercing, restless, black eyes, and a short, sharp, quick speech. I do not think any student ever scored off C. H. W. In those days the Medical School Office used to be a sort of Students' Bank. When one received a cheque from home one took it in to Mr. Wells. He cashed it for you, giving you the face value of the cheque, less a small deduction. I presume that deduction was made to cover the risks incurred in carrying out the transaction. I often wonder whether Wells ever cashed a "stumer." I very much doubt it. His wonderful acumen for finance led to his becoming Secretary to the Treasurer. This was at a time when a great appeal for funds was being made to the public, on behalf of the Hospital. That appeal was instituted, in the first place, by Mr. Gladstone, but put before the public by H.R.H. the Prince of Wales, afterwards King Edward VII., and a most successful appeal it was. We should not be in the position we are in to-day but for the success of that appeal. Mr. Wells had other interests outside the Hospital, and so successful were they that when he died, only a year or two ago, he left a very considerable fortune. He did not forget his early associations; eventually the bulk of that large fortune reverts to the Medical School.

Morley, as janitor, was a man apart. Most of you here remember Morley. He attended all Lectures, and it was his duty to take the names of the men who were present. I do not believe he ever received a bribe to sign a man up for more lectures than he attended. I do not believe any man ever had the temerity to attempt to bribe him; if he had, I should be very sorry for him. He was a man of very few words, but had a wonderful memory for faces. He asked you your name the first time he saw you, and he never forgot it. His recreation was music and he had a very good bass voice. He was a member of the Royal Choral Society, and used to sing in the choir at the Royal Albert Hall. Only once in my life did I see Morley express any great emotion, and that was when he told me of the death of his only son during the late war. As you know, he retired a little while ago. I trust he is enjoying his pension, as he is certainly enjoying the good will of everybody with whom he came in contact here. Apparently there has been no actual successor to Morley; his duty has been divided up among other people. Incorruptibles are difficult to find.

One of the most interesting characters on the Medical School staff, when I came to Guy's, was old Betts, who had charge of the Museum. He was a short, stocky little man, nearly bald, with but a fringe of white hair. He had very keen eyes that looked at you without a quiver through his spectacles. Betts' little sanctum was down three steps at the end of the old bone Museum, in the block of buildings that I spoke of just now. There we students waited upon him to borrow bones for study purposes. If Betts liked you, you would get a good bone; if he did not like you the bone you received was always a damaged specimen, and the part you most wanted was absent.

Betts had an assistant whose name was Hoare. He was a very sombre individual. He always dressed in black, always wore a black tie, and a black hat, and carried a black bag and umbrella. I never saw him dressed in any other way. He would have made an admirable mute at a funeral. He was nearly as old as Betts, who treated him as if he were a little boy. He was thoroughly afraid of Betts, and had no love for him. Although he was a very much bigger man than Betts he never had the courage to stand up to him. When he wanted to let off steam after a bad time with Betts, he used to go out to the Park and feed the pigeons. Or you would see him walking round and uttering oaths and imprecations under his breath, and shaking his fists bewhiles. Talking of language reminds me of the story of the father who took his little boy to the Zoo one Sunday afternoon. Just outside the Monkey House the father slipped up on a piece of orange peel, and his language was as violent and highly coloured as that of the Mandril in the adjacent cage. When the outburst had subsided and the small boy had recovered his father's hand, they were walking on, and the little boy looked up and said, "Father, how did you know that was a blood orange."

Many years ago when the question of the Darwinian theory as to the descent of man from some ape-like ancestor was discussed in the halfpenny evening newspapers, a youthful reporter on the staff of the now defunct *Echo* came down here to interview our lecturer on Anatomy, hoping to secure some copy for his paper. The lecturer on Anatomy was away, but old Betts received the reporter instead and told him that Mr. Clement Lucas had conducted a considerable amount of research in the matter and that all his research tended to confirm the views of Darwin. Pointing to one of the Museum stools he drew the young man's attention to the slit in the seat. Of course the slit is made to slip the fingers through when carrying the stool

from place to place. Betts told him that Mr. Lucas had found that in the earliest forms of stools known to be used by man, the slit in the seat was made larger and round in order to accommodate the tails of prehistoric men when seated. Well, Betts and Hoare are now walking in the Elysian Fields, arm in arm, I trust, and sharing each other's tobacco.

Physiology was not so important in my day as it now is. We had no teacher of the standing of Professor Pembrey, or anybody like that. We had one surgeon who lectured on Physiology, namely Mr. Golding-Bird, and he had an assistant in the Physiological Department then, as now, of the name of Baker. Baker had been an old soldier, and was a married man with a large family. Each session when Mr. Golding-Bird lectured on Respiration, one of Baker's boys used to be brought into the Theatre and laid on the table, and was used to demonstrate the correct method of performing artificial respiration on the apparently drowned. Mr. Golding-Bird always had a little joke. He said to the boy, "How old are you?" "I'm ten years old, sir." "You told me you were ten last year." "No, it was my brother who came up last year." This went on for several years and the boy was always aged "ten."

Baker's great friend was Jimmy Stockwell, Hancock's predecessor in the Anatomical Department. I remember there was no shortage of parts in those days. Jimmy Stockwell's tanks would have gladdened your heart, sir; they were always full to the brim. There were never more than two students on a head and neck. The first head and neck I ever had I shared with Gowland Hopkins, the distinguished professor of Bio-Chemistry at Cambridge. I said that Jimmy Stockwell was Baker's great friend. Earlier I told you that there used to be some gates at the end of the Broad Walk leading into Newcomen Street. When you passed these gates, a few steps led you to a hostelry, which I think is still there, called "The Angel." Baker and Jimmy Stockwell paid many visits thither and they used to return with specimen jars from the Museum filled with a sparkling brown fluid. I never saw any specimens in the Museum mounted in a fluid of that colour, although I do not doubt that Hunt has more than one liver under his care that owes its immortality to this same brown fluid. Baker died, and Stockwell left, and, I think, became a dock policeman.

In March, 1890, the College was opened. We had a great day. Mr. Gladstone, who was then Senior Governor of the Hospital, came down and was entained at luncheon in the College, and afterwards made a great oration. I was re-reading it only the other day. Anything that Gladstone said was worth reading; he was most eloquent. I had the good fortune to hear him make that speech.

Dr. Perry was appointed the first Warden of the College. There were two porters—we will call them A and B—and they alternately took turns at day and night duty. It was the duty of the man who was on at night to look after the gates and doors and also to clean the boots. I remember one night in March, after a successful cup tie at Richmond, that B, in common with many others, celebrated the victory "too well." About midnight someone in the College found him helpless in his chair in the lodge, and blackened his face with boot polish. Later on, when more revellers, returning from another part of the town, rang the bell, they could not wake B. But they succeeded in attracting the attention of the Warden, who came down and let them in, and discovered the condition of B. Then B. was carried across to the Front Surgery and washed out with a stomach pump and put to bed. The Warden sat in the chair in the lodge the rest of the night, and cleaned the boots.

Then there was Copsey. Copsey was a reservist and rejoined the colours when the South African War broke out. Before he went I made him some artificial teeth. When he returned I asked him how he had got on. He said, "I got on alright, sir, and those teeth you made me have done some good work. There were a lot of chaps wanted to borrow them, but I wouldn't part."

Speaking of Superintendents reminds me that when I came Dr. Steele was Superintendent of the Hospital. He was a portly and courtly gentleman. With his side whiskers he looked a typical family doctor. Everybody liked him. He had certain little peculiarities. We all have. One of his peculiarities was this. He used to visit every ward every day, and always in company with the matron. When he entered the ward he was received by the sister, and they walked solemnly to the end and back again. Dr. Steele was never known to remove his silk hat in the ward. In 1892 he was seized with acute intestinal obstruction, and although Dr. Durham operated on him, the same evening he never recovered.

The matron was Miss Victoria Jones. Miss Jones was a great disciplinarian. I think I may say truthfully that everybody in the Hospital went in awe of her. But she always had the welfare of her staff in mind. Mr. Beckwith was telling me the other day that he remembers her coming to the Superintendent's Office, bearing a piece of meat on a plate. Placing it down in front of dear old Prior she bade him look at it. "I am looking at it. Matron." "Well, eat it," she said.

I remember quite well one afternoon that my old friend, Dr. Peter Paget, a house surgeon at the time, came to me and said, "Hopson, we've got a nice job on!" "What do you mean?" "Well, the Matron is suffering badly from toothache, and I have got to give the gas, and you to take the tooth

out in Clinical Private Room." I do not think there could be two men in a greater panic than he and I were in at that moment. Peter Paget was quite sure that she would die under the anæsthetic, and I was as certain that I would smash up her tooth. Paget gave her the gas, and fortunately the tooth was loose and came out alright; and she entertained us to tea. I believe Miss Victoria Jones is still alive, and if so she must be an old lady, and I hope she will go on living for many years.

The old Front Surgery used to be in the *front* where the Light Department now is. In those days dear old Auntie Keogh, as we called her, ran the Front Surgery. She was a delightful creature. Everybody loved her. Her knowledge was profound. If a patient was brought in, and it was a question whether he was drunk, or whether he had a fractured base, Auntie's opinion was relied on. If he had to be taken in or an assistant surgeon had to be summoned, everybody did what Auntie Keogh said should be done. She had been at the Hospital a great many years. One day, in the Borough, she slipped and fractured her femur. As not infrequently happens to elderly people, she developed pneumonia and died where she would wish to die—in a ward of the Hospital.

I have told you that the old Front Surgery was where the present Light Department now is. There was a door out of that Surgery that led to what were known as the Old Residents' Rooms. The Residents occupied rooms where Mr. Curry's offices now are. Many revels took place there. I remember one. It was after Richmond. Lots of these things happen after Richmond. At that time Dr. Peter Horrocks. Obstetric Physician to the Hospital, like a great many other celebrated men, lived in St. Thomas's Street. He was a bachelor and he had one or two students living with him as boarders. One of his boarders was present at these revels in the Old Residents' Rooms. About two o'clock in the morning we thought it was time this man went home to Peter Horrocks'. He was in a condition to be helped, and to assist matters about half-a-dozen empty sardine tins were tied on to the back of his coat. We got him down to St. Thomas's Street, abstracted the key from his pocket, opened the door, put him inside, and went away. The man's bedroom was at the top of the house, and on the way he had to pass Dr. Horrocks' room. Dr. Horrocks very naturally awoke, and he overheard the man say to himself, as he passed his bedroom door, "This is a bit of luck, old Peter will never hear me come in with all this noise going on."

Many of you will remember Coles who used to be attendant in the Operating Theatre, that old, dear septic place where we used to go in, one hundred strong, to watch operations. Coles' duty was to attend the surgeons when operating, and look after all the instruments and see that they were in a fit condition to use. It was not a particularly easy post to fill, because surgeons have their little idiosyncrasies. I am thinking particularly of one of our consulting surgeons. If Coles handed him a knife it was "blunt," if a saw it would never cut. Although he was very brusque in his speech, he was one of the kindliest of men; when he realised that he had said a harsh thing he was the first to make amends. How good he was to his patients many of them would testify. There was another man we all knew quite well who passed away quite recently—Bell. He was in the Pathological Department. He came to Guy's in 1893, and was a good sportsman, though of a retiring manner. Everybody liked him. He held that post in the Pathological Department longer than anybody else. There used to be frequent changes in it.

An amusing thing happened in the Department some years ago. There was a case in one of the medical wards under Dr. "X." It was an obscure case and the man died and found his way to Bell's Department. Dr. "X." was most anxious to secure the spinal cord, in order that it might be examined and sections made. He went to Bell and got the cord, but unfortunately, while washing it, it slipped out of his hands and went down the waste pipe of the sink like a snake. Off went Dr. "X." and tore across to the Superintendent, demanding the plans of the Hospital drains in order that the lost cord might be intercepted. The Superintendent calmly said the best thing Dr. "X." could do would be, perhaps to-morrow or the next day, to go down the river to Gravesend or wherever the London sewers go into the Thames and wait for it.

Bell, as you know, died only a year or so ago, and I need hardly say that his death was much regretted, for everybody liked him. In Bell the Hospital lost a faithful and valuable servant.

This slide (shown on screen) represents the first Conservation Room ever built here, which stood where the Dental Buildings now are. That drawing appeared in one of the first numbers of the *Daily Graphic* newspaper, on October 1st, 1890. One of their representatives came down and made the sketch. I put it on the screen to draw attention to the old lady in the corner. She was an old Irish woman—I have forgotten her name—and the first attendant we had in the Dental Department. I remember very well that the first Christmas after she came the half dozen dental students then in the school presented her with a goose. I went over to Leadenhall Market and bought that goose, and paid for it by weight; a good heavy goose bought at so

much a pound. When the dear old soul had got it home it turned out that the great weight was owing to the fact that it was stuffed tight with wet brown paper.

When the Dental School had got a nice new building, there came a time when someone of greater importance and with greater knowledge should occupy some position, such as that of Lady Clerk in the Conservation Room. The first lady clerk was Miss Upham. The senior member of the Staff at that time was a bachelor who did not approve of employing women in such a capacity, but his views were overborne by the rest of the Staff and she was appointed. That senior member of the Staff was the first, I am bound to say, to pay his compliment of appreciation to Miss Upham for the able manner in which she performed her duties; and the way in which the Conservation Room is now run is largely due to the valuable services Miss Upham rendered in that Department.

I pass now to the other end of the Hospital—the old Out-Patient Department. Originally the Dental Department consisted of one small room which was used for extractions on two mornings in the week. Then we shared another room with the Aural Surgeon, this being used for gas patients. I remember, many years ago, we had a man in there from the Borough Market. Sir Alfred Fripp, who was then the anæsthetist, gave him gas, and the man took it well. We were all standing by waiting for him to come round. Suddenly he leaped up and fled through the Out-Patient Department. At the door a portly porter endeavoured to stop him; not being an "Albertijn" he missed his collar and the man raced up the Maze Pond and disappeared round the corner of St. Thomas's Street. About an hour afterwards he came back for his hat and coat and three teeth he had had out. I said, "What about it?" He replied, "I don't know nothing about it. When I come to I was in a pub down the Borough, and there was a pint of beer in my hand." I could not help thinking, if that porter had only known, if he had even kept him in sight!!

Then there was old Mrs. Tipping, who helped us in the Gas Room. Later she had charge of the refreshment stall in the Out-Patient Department. When I used to look at what she had for sale, I always thought it was a merciful Providence that located her stall next door to the Dispensary.

Mr. Collier was Dispenser in those days, and very popular he was. We used to go down into the bowels of the earth there to receive instruction from him. He provided very useful printed lists of tips and such like, for the Materia Medica and Pharmacy examinations. Not only had he a distinguished son here, but I understand that there is a grandson of Mr. Collier now a student in the Medical School. Of course, Mr. Collier retired a great many years ago.

The Dental School with which I am connected has always had close contact with the Works Department; it seemed as if we should never part company. I hear, however, that a severance will shortly take place. The Clerk of the Works in those days was Mr. Chapman, and a very great work was done in that Department under Mr. Chapman. He was a very tall, heavy, slow-walking, and rather slow-speaking man. There was an amusing little incident that I do not mind telling you about Mr. Chapman—nothing at all to his discredit. I told you that in the early days there was a small Extraction Room used on two days each week. In that room there was a most lovely dental chair originally belonging to Mr. Salter, a celebrated dentist. It was a beautiful, leather-covered chair, and most comfortable to sit in if you could get rid of the associations. That chair gave way to another not so ornate, but certainly more serviceable. When the Dental Society was founded, it occurred to me that the former would make an admirable chair for the President to sit in at its meetings. The Superintendent said, "You can have it; go and see Chapman about it." I went to see Mr. Chapman, and said, "You remember that chair which used to be in the old Dental Department?" "Yes." "Do you know where it is?" "I will make inquiries about it." "Alright." About a fortnight afterwards I saw him again, and I said, "Have you found that chair?" He hummed and hawed about it, and then he said, "I've got it at home; it makes a most comfortable easy chair." We left it with Chapman. I am sure he deserved it.

That is a figure (on screen) that a great many of you will remember—Mr. Henry Williams, who was for so many years Clerk to Guy's. Everybody knew him with his white hat. When the winter came on he wore an overcoat, and a shawl over that.

Some years ago I was motoring in South Wales and stopped at Ross for the night. Guy's owns large estates in the neighbourhood of Ross, farms and such like. At the hotel where I put up, I noticed just before dinner that there were a lot of people assembled, consisting of the farming class, and believing that there was some special function on, I said to the manager of the hotel, "You have got a Dinner on to-day?" "Yes, it is Guy's Hospital Rent Audit Dinner." "Who is down here?" "Mr. Williams, sir." After I had had my own dinner I went into Guy's Hospital Rent Audit Dinner, and there I saw Mr. Williams at his best. He was presiding over this Dinner. It might have been the President of the Hospital, or the Prince of Wales himself, so well was he doing the honours of the evening. There was nothing for it—I was drawn into it and had

to make a speech. They had a jolly good dinner at that hotel.

Mr. Henry Williams had interests outside the Hospital. Amongst other things, he was a churchwarden. He died, as you know, not so many years ago.

Speaking of churchwardens, I am reminded of another churchwarden, "Boss" Milson. In 1894 I spent a holiday in Norway. You know that to get to Norway, unfortunately, you have to cross the North Sea. It is, I am told, a shallow sea, and that is why it is so often very rough. I am one of the worst sailors. I was crossing from Harwich to Bergen, and after we got out to sea I chose a sheltered place on deck and wrapped in a thick ulster and wearing a muffler of the Guy's colours, there awaited events! Presently the captain of the ship came along, and when he got opposite to me he spotted the Guy's colours and said, "Do you know 'Boss Milson?" I said, "I do and I would I were in his ship and not yours." Fortunately for me it happened that the skipper of the boat was a friend of various other Guy's men of my time, hence I reached Bergen in greater comfort.

Before the College was built the Students' Club was housed in an empty ward which is now "Stephen," Prior to the Prince's Appeal one or two wards had to be closed. The catering in that ward for the Students' Club was run by Milson, of "The Ship and Shovel." It was very well run and cheap. I will tell you why it was cheap. There was a centre-table down the middle, a bar at one end, and little tables along the sides, and one or two little boys, who wore white coats, from some Charity School in the neighbourhood acted as waiters. All the cold things were placed on this table in the middle of the room. You helped yourself to what you thought you liked, and carried it on to one of the side tables and had your lunch. You got what you wanted and when you had finished you went up to the bar, declared what you had had and paid for it. That is why it was cheap. When later the College was opened, Milson, for the first year or two, did all the catering. Henry Milson was a churchwarden of St. Thomas's Church, St. Thomas's Street.

I started at the Front Gates and I leave you at "The Ship and Shovel."

Before I sit down I just want to say this. All of us at Guy's—no matter whether we are governors, or members of the staff, or nurses, or employées, or students—all of us owe our positions here, first of all to Thomas Guy. But we also owe a very great deal to those who have gone before us. Those who worked in this place before our time set us an example of high endeavour, self-denial and tenacious devotion, which we desire, to emulate. We are anxious to keep up the traditions which Guy's has made. We are anxious to fulfil old Thomas Guy's ideals and the objects for which he founded this Hospital—the relief of the sick and deserving poor. We can only maintain the traditions of Guy's by everyone doing his best, and working together, for we are all of us dependent upon one another. This Hospital could not be run without the loyal, willing service of the members of your Association. We know that and, believe me, we realise it, and we are grateful to you.

It may be that in thirty or fifty years another audience seated in this same theatre may be listening to better stories, better told, about ourselves, and wherever we may happen to be, in whatever sphere we may then be dwelling, I sincerely trust that it may be so ordained that we shall not only hear those stories, but be able to join heartily in the laughter which they are sure to evoke.

Note.—The excellent lantern slides used to illustrate the Address were prepared by Mr. Walker of the Biological Department.—M. F. H.

A Case of Thrombosis of the Cavernous Sinus due to Infection from a Superficial Skin Lesion.

By GRAYDON HUME.

Grace M., aged 19 years, was admitted into Ruth Ward in January, 1919, under Mr. Ormond's care.

The patient was sent up from Ware by her doctor on account of proptosis of the right eyeball, with paresis of the extrinsic ocular muscles, chemosis, and right-sided blindness. For four days she had suffered from great pain in the eye, headache, rigors and vomiting; she had also sweated.

On examination of the right fundus, Mr. Ormond noted marked papilloedema. Patient suffered from headache and insomnia, though she was drowsy and had delayed cerebration. Temperature 101°F.; pulse 80. Examination of the nose by Mr. Mollison revealed no abnormality. At the upper part of the nose, towards the right inner canthus, there was a small pustule which had been present six days. There were no signs of diffuse meningitis, and the sudden onset of the condition excluded the presence of a tumour.

The fact that there was no marked orbital cellulitis or bone tenderness excluded retro-orbital pus formation. The proptosis, chemosis, rigors, sweating, pain and vomiting pointed to a diagnosis of cavernous thrombosis.

In the hope of finding some focus of suppuration in the posterior ethmoidal cells or sphenoidal sinus,

operation was decided upon. Chloroform with oxygen from a Junker apparatus was administered by Mr. Ord. Mr. Mollison operated.

An incision was made beginning just under the eyebrow, curving round the inner canthus down on to the side of the nose; the inner orbital wall was exposed by pushing the periosteum outwards. The lateral mass of the ethmoid was removed and the sphenoidal sinus reached, but no pus was encountered; the posterior wall of the sphenoidal sinus was attacked in order to reach the cavernous sinus. Some dark blood clot was removed from this region until distinct oozing of blood occurred. Patient was apparently in slightly improved condition twenty-four hours after operation; but later she became unconscious and died nine days after the operation.

At the post-mortem examination massive clot formation with streaky extra-dural pus was found radiating from the cavernous sinus. The causative organism was not determined, but undoubtedly the path of infection was via the nasal emissary or communicating vein and originated in the superficial septic area in the eyelid.

Thrombosis of the cavernous sinus may occur in various ways; the infection may spread—

1. Through the superior petrosal sinus from suppuration in the temporal bone or maybe an extension of thrombosis of the lateral sinus.

2. Through the veins passing from the face through the orbit to the sinus; by this path carbuncles may cause thrombosis.

3. Through infection from the nasal sinuses.

4. Through the pterygoid plexus which communicates with it, and which may be infected from the pharynx, *e.g.*, peritonsillar abscess.

The case above quoted is an example of the second group; its interest lies in the apparently slight nature of the infecting focus. It is possible that lowered resistance due to inadequate feeding during the war may have been a factor in the case.

Reviews.

A Practical Guide to Surgical Operations, Instruments and Appliances. By William Ibbotson, M.R.C.S., L.R.C.P.

This book gives, in a very clear and concise form, the various instruments necessary for any operation. In some instances the numbers are rather large, but that, of course, is a good fault.

In the Introduction the author mentions many things which should be most valuable to the nurse in private work, particularly the details given about preparing for operations in private houses.

The methods of the sterilization of sutures and ligatures are very completely given; also the care and sterilizing of instruments.

There should be no hesitation in recommending this book, as it is an excellent guide to all, especially to nurses.

Football.

RUGBY.

GUY'S v. DEVONPORT SERVICES.

This game was played on Monday, December 5th, at Honor Oak Park. Many wondered why a game of such interest should have been fixed for such an awkward day. The reason is that the match had to be played on that day because the Services were on the Saturday at Northampton. They thus embraced the two fixtures on the one journey. Doherty was still away, and from the team that did so well against Swansea on the previous Saturday Graham-Davies, Fouraker and Zondagh were absent. The Services had E. R. Gardner, an International forward, in their pack. At scrum half was Knapman, who has figured in the trials as a scrum half, while Kershaw has been in America; and at full back was F. Gilbert. The last named needs no introduction; he is a veteran at the game and has played in more than one International trial. The old English Captain, Commander Roberts* was on the stand. It is said he had an eye on Gardner, Knapman and Gilbert; one hopes his other eye may have been on Bekker, Neser and Taylor, not to mention Albertijn.

The game was scrappy and ended in a pointless draw. Our men were somewhat tired as a result of their previous hard game. Many times the Devonport team flung the ball about quite indiscriminately, but our forwards were too weary to dash up and reap full advantage of their opponents' mistakes. Taylor was limping and Harvey, who did well, was also lamed. The tackling of both sides was distinctly good; there was no half-heartedness about that, and the show piece of the afternoon was Gilbert's full back display. I think our three's helped him, by punting instead of running, and Crisp, who was not at his best, seemed compelled to find Gilbert instead of touch. Once during the first half Steyn missed a chance. He cleared the field, cleverly side stepping, but did not attempt to get by Gilbert, kicking across without result. Neser attempted a penalty but the shot went wide. Once or twice the opposing forwards got down on Crisp before he cleared.

*An English International Selector.

The second half was a repetition of the first, and towards the end, our men tired. They might easily have achieved victory had our threequarters passed more quickly and at a faster pace. Daneel and Steyn put in some runs, but the movement was not quick enough to overlap the defence. Just on time Daneel was bundled into touch. Steyn had a long drop and then came some excellent handling, Albertijn being tackled just as he had drawn his man and was about to pass. From the ensuing scrum, Van Schalkwijk missed a drop in front of the posts. This player is usually sureness itself at this particular form of scoring. One must speak highly of Biddle, Watson and Duncan. They and all the players are to be congratulated in that they avoided defeat, even if they did not gain victory—this after 4 hard matches in 9 days.

Guy's Team—E. J. Crisp, A. Daneel, P. K. Albertijn, J. G. Van Schalkwijk, C. L. Steyn, F. Bekker, E. L. Sprong, R. F. H. Duncan, E. E. Neser, W. H. Taylor, L. K. Watson, F. J. Biddle, P. G. Harvey, H. G. Close, N. G. Holloway.

GUY'S "B" v. ST. JOHN'S SCHOOL, LEATHERHEAD.

Played at Leatherhead on November 16th, and resulted in a win for us by 9 points to nil. It was a forwards' game, for the ball was wet and difficult to handle. In the loose, the School, who played seven forwards and five three-quarters, held their own, but in the tight scrums we usually pushed them off the ball. At half-time we were three points up as the result of an individual effort by W. Orsmond.

In the second half the same player crossed the line twice, running well on both occasions. None of the tries was converted, for the kicking was deplorable.

Guy's Team—D. S. Huskisson, J. C. Young, E. H. Berry, V. R. Estment, W. Orsmond, M. T. Aung, C. L. Worthington, E. Orsmond, C. Ive, H. L. Eckhoff, Russell, F. F. Brayfield, W. A. Mill, R. D. Gross, F. Marsh.

GUY'S "B" v. BART.'S "B."

Played at Honor Oak Park on November 23rd. In the first quarter of an hour Bart.'s were dangerous several times, their forwards heeling well and their backs showing speed and good combination. As the result of one movement their left wing three-quarter crossed the line far out, to run in and touch down behind the posts. The try was converted. Our forwards now began to get the upper hand and pressed hard, E. Orsmond eventually getting over far out. The try was not converted. There was no further scoring before half-time. In the second half our forwards predominated; Cameron scored by a good individual effort, and Estment by a good follow-up. These tries were not converted. A further try was obtained by a mistake of the Bart.'s half—the ball being taken from his possession and touched down by one of our men. The kick was successful, thus bringing the final score to 14 points to 5 points. Our backs, though good in defence, rarely looked dangerous, due mostly to the remarkable position they took up.

Guy's Team—D. S. Huskisson, J. C. Young, W. Orsmond, E. H. Berry, Craib, G. B. Longhurst, O. P. James, E. Orsmond, Cookes, V. R. Estment, Cameron, H. L. Eckhoff, J. A. Currie, Russell, F. F. Brayfield.

GUY'S "B" v. CHRIST'S HOSPITAL "A."

On Saturday, December 10th, Guy's "B" defeated Christ's Hospital "A" XV. by 27 points to nil. It would seem from the score that Guy's had all of the game, this was by no means the case.

On a glorious morning the team travelled down to West Horsham. They were met at the station, and shown all over the fine new school, and entertained to lunch.

The game started fast; the School were packing with 7 forwards, and at first 8 forwards were too heavy for them, and with excellent play in, and behind the scrum Guy's were soon 10 points up. W. Orsmond was responsible for all 10. Soon, however, the rate of scoring slackened, but a few tries were secured by Guy's backs, all playing well.

After change of ends, the younger schoolboys showed to advantage their greater staying powers, and the game continued hard and fast. The 7 were getting the ball from the scrum time and again, but bad luck prevented a score on several occasions.

Guy's added a few more points, and an excellent and interesting game came to an end only too soon. We regret that twelve months must elapse before such a welcome fixture again appears on the card.

Guy's Team.—Trist, Young, Craib, Orsmond, W., Brock, Aung, Berry, Currie, Orsmond, Eckhoff, Brayfield, Russell, Mill, Hopson-Jones, Gross.

THE EDITOR will, at all times, be glad to consider articles or sketches, provided that they are accompanied by the writer's name and address, not necessarily for publication. The payment that the GAZETTE *can offer is merely nominal. Authors who desire reprints of their papers should make their own arrangements with the printers when they return their proofs. All contributions to be addressed to the Editor, "Guy's Hospital Gazette," Guy's Hospital, London, S.E.*

Birth.

ERULKAR.—On October 31st, at Imperial House, Leamington Road, Bombay (4), India, to Kitty, wife of Abraham S. Erulkar, M.B., B.S. Lond., a daughter.

Death.

ALLAN.—On the 10th December, at 41, Croham Road, Croydon, Ann, widow of John Allan, formerly of Calcutta, in her 93rd year.

ED.—A. T. R.